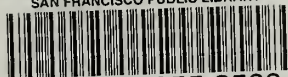


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# LAGUNA HONDA HOSPITAL REPLACEMENT PROPOSED MEETING SCHEDULE

## PLANNING COMMITTEE

*(Every 2nd & 4th Tuesdays)*

Date	Time	Location
02/09/99	3:00 - 5:00pm	Main Library, Latino/Hispanic Comm. Rm.
02/23/99	1:00 - 3:00pm	LHH, Simon Auditorium
03/09/99	1:00 - 3:00pm	25 Van Ness, Room 330A
03/23/99	1:00 - 3:00pm	LHH, Simon Auditorium
04/13/99	1:00 - 3:00pm	25 Van Ness, Room 330A
04/27/99	1:00 - 3:00pm	25 Van Ness, Room 330A
05/11/99	1:00 - 3:00pm	TBD
05/25/99	1:00 - 3:00pm	TBD
06/08/99	1:00 - 3:00pm	TBD
06/22/99	1:00 - 3:00pm	TBD
07/13/99	1:00 - 3:00pm	TBD
07/27/99	1:00 - 3:00pm	TBD
08/10/99	1:00 - 3:00pm	TBD
08/24/99	1:00 - 3:00pm	TBD
09/14/99	1:00 - 3:00pm	TBD
09/28/99	1:00 - 3:00pm	TBD
10/12/99	1:00 - 3:00pm	TBD
10/26/99	1:00 - 3:00pm	TBD
11/09/99	1:00 - 3:00pm	TBD
11/23/99	1:00 - 3:00pm	TBD
12/14/99	1:00 - 3:00pm	TBD
12/28/99	1:00 - 3:00pm	TBD

## TECHNICAL SUB-COMMITTEE

*(Every Wednesday)*

Date	Time	Location
02/17/99	3:00 - 5:00pm	25 Van Ness, Room 330B
02/24/99	3:00 - 5:00pm	25 Van Ness, Room 330B
03/03/99	* 3:30 - 5:30pm	25 Van Ness, Room 330B
03/10/99	3:00 - 5:00pm	25 Van Ness, Room 330B
03/17/99	3:00 - 5:00pm	25 Van Ness, Room 330B
03/24/99	3:00 - 5:00pm	25 Van Ness, Room 330B
03/31/99	3:00 - 5:00pm	25 Van Ness, Room 330B
04/07/99	3:00 - 5:00pm	25 Van Ness, Room 330B
04/14/99	3:00 - 5:00pm	25 Van Ness, Room 330A
04/21/99	3:00 - 5:00pm	25 Van Ness, Room 330B
04/28/99	3:00 - 5:00pm	25 Van Ness, Room 330A

## PROGRAM SUB-COMMITTEE

*(Every Wednesday)*

Date	Time	Location
02/17/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.
02/24/99	9:00 - 11:00am	25 Van Ness, Room 330B
03/03/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.
03/10/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.
03/17/99	9:00 - 11:00am	25 Van Ness, Room 330B
03/24/99	9:00 - 11:00am	25 Van Ness, Room 330B
03/31/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.
04/07/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.
04/14/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.
04/21/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.
04/28/99	9:00 - 11:00am	1380 Howard, CSAS 4th Floor Conf. Rm.

## FINANCE SUB-COMMITTEE

*(Every Friday)*

Date	Time	Location
02/19/99	9:00 - 11:00am	101 Grove, Room 220
02/26/99	9:00 - 11:00am	101 Grove, Room 220
03/05/99	9:00 - 11:00am	101 Grove, Room 220
03/12/99	9:00 - 11:00am	101 Grove, Room 220
03/19/99	9:00 - 11:00am	101 Grove, Room 220
03/26/99	9:00 - 11:00am	25 Van Ness, Room 330B
04/02/99	9:00 - 11:00am	25 Van Ness, Room 330B
04/09/99	9:00 - 11:00am	101 Grove, Room 220
04/16/99	9:00 - 11:00am	101 Grove, Room 220
04/23/99	9:00 - 11:00am	25 Van Ness, Room 330B
04/30/99	9:00 - 11:00am	101 Grove, Room 220

**Laguna Honda Hospital Replacement Planning Committee  
San Francisco Public Library  
Latino/Hispanic Community Room  
100 Larkin Street (between Grove and McAllister)  
February 9, 1999  
3:00 p.m. – 5:00 p.m.**

*Noema Satin*

**AGENDA**

- |              |  |                    |
|--------------|--|--------------------|
| <b>I.</b>    | <b>Welcome and Introductions</b>   | <b>3:00 – 3:15</b> |
| <b>II.</b>   | <b>Review and Approval of Agenda</b>   | <b>3:15 – 3:20</b> |
| <b>III.</b>  | <b>Purpose of Laguna Honda Hospital<br/>Replacement Planning Committee</b>   | <b>3:20 – 3:40</b> |
| <b>IV.</b>   | <b>Review Key Policy Issues</b> <ul style="list-style-type: none"><li>• <b>Planning Committee</b></li><li>• <b>Program Sub-Committee</b></li><li>• <b>Finance Sub-Committee</b></li><li>• <b>Technical Build Sub-Committee</b></li></ul> | <b>3:40 – 4:20</b> |
| <b>V.</b>    | <b>Communications Plan</b>   | <b>4:20 – 4:30</b> |
| <b>VI.</b>   | <b>Planning Process Timeline</b>   | <b>4:30 – 4:45</b> |
| <b>VII.</b>  | <b>Meeting Schedule</b>  | <b>4:45 – 4:55</b> |
| <b>VIII.</b> | <b>Next Steps</b>  | <b>4:55 – 5:00</b> |
| <b>IX.</b>   | <b>Adjournment</b>   |                    |



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**Laguna Honda Hospital Replacement Planning Committee  
Briefing Binder**

Tab No.	Content
1	List of Committee and Sub-Committee Members
2	Schedule of Meetings
3	Committee and Sub-Committee Charge
4	Project Timeline
5	Laguna Honda Hospital Options Paper dated December 10, 1998
6	Data on Long-Term Care and Skilled Nursing Care Need and Capacity
7	Finance Issues (Finance Sub-Committee)
8	Program Issues (Program Sub-Committee)
9	Technical Build Issues (Technical Build Sub-Committee)
10	Meeting Minutes and Notes









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**Laguna Honda Hospital Replacement Planning Committee**  
**SCHEDULE OF MEETINGS**

(Draft meeting schedule to be distributed and discussed at February 9, 1999 meeting)









## **Laguna Honda Hospital Replacement Planning Process**

### **Committee and Sub-Committee Charges**

#### ***Laguna Honda Hospital Replacement Planning Committee***

The Planning Committee will be charged with making recommendations on the rebuilding of Laguna Honda Hospital (LHH). Recommendations will be made in the areas of finance, program design and technical rebuilding issues. The Committee's recommendations will form the basis for a submission to the Board of Supervisors on the timeline and type of facility that is needed. The Planning Committee will make its recommendations to the San Francisco Health Commission.

Specifically, the Planning Committee will address the following:

- How many skilled nursing beds should the rebuilt Laguna Honda Hospital have? (Program Sub-Committee)
- What distribution of single, double and 4-bed rooms should the Hospital have? (Program Sub-Committee)
- What supportive and social services should be housed within the Hospital? (Program Sub-Committee)
- How should space be allocated to various departments on the Laguna Honda Hospital campus (e.g., outpatient, clinical, support, patient activity, etc.)? (Program Sub-Committee)
- Should construction be done on the Clarendon Hall site and if so, what service(s) should be placed there (e.g., assisted living)? (Program Sub-Committee)
- What are the projected costs of replacing Laguna Honda Hospital? (Finance Sub-Committee)
- What sources of funds can be used to finance the costs of replacing Laguna Honda Hospital? (Finance Sub-Committee)
- What are the operational costs of the rebuilt facility and how will these costs be funded long-term? (Finance Sub-Committee)
- Is a revenue bond necessary or preferable for rebuilding Laguna Honda Hospital? (Finance Sub-Committee)
- What is the project's timeline and project work plan for replacing the Hospital? (Technical Build Sub-Committee)
- What are the potential impacts on neighborhood and surrounding amenities? (Technical Build Sub-Committee)
- What disruption in operations and /or traffic circulation problems arise? (Technical Build Sub-Committee)
- What designs promote a non-institutional environment? (Technical Build Sub-Committee)
- What are the operational efficiencies that result from replacing the Hospital? (Technical Build Sub-Committee)

# THE HISTORY OF THE UNITED STATES

The history of the United States is a story of growth and change. It begins with the first people who lived on this land, and continues through the years of exploration, settlement, and the struggle for independence. The story is one of a people who have built a great nation, and who are still building it today.

The first people who lived on this land were the Indians. They were here long before the Europeans came. They lived in small groups, and they were very skilled at hunting and farming. They were also very brave, and they fought many wars with each other.

The Europeans came to this land in the 15th century. They were looking for new places to settle, and they found a land that was full of opportunity. They brought with them new ideas and new ways of life, and they began to build a new nation.

The story of the United States is a story of many different people, and of many different things. It is a story of the people who have built this nation, and of the things that have made it what it is today. It is a story of growth and change, and of the struggle for a better life.

***Laguna Honda Hospital Rebuilding Program Sub-Committee***

The Program Sub-Committee will be charged with making recommendations on the appropriate array of programs and services that should be contained within the rebuilt Hospital and on the campus of Laguna Honda. The Sub-Committee will make its recommendations to the Laguna Honda Hospital Replacement Planning Committee for consideration.

***Laguna Honda Hospital Rebuilding Finance Sub-Committee***

The Finance Sub-Committee will be charged with examining the costs and financing issues related to rebuilding the Hospital. The Sub-Committee will make its recommendations to the Laguna Honda Hospital Replacement Planning Committee for consideration.

***Laguna Honda Hospital Rebuilding Technical Build Sub-Committee***

The Technical Build Sub-Committee will be charged with assessing the technical aspects of any rebuilding option. The Sub-Committee will make its recommendations to the Laguna Honda Hospital Replacement Planning Committee for consideration.

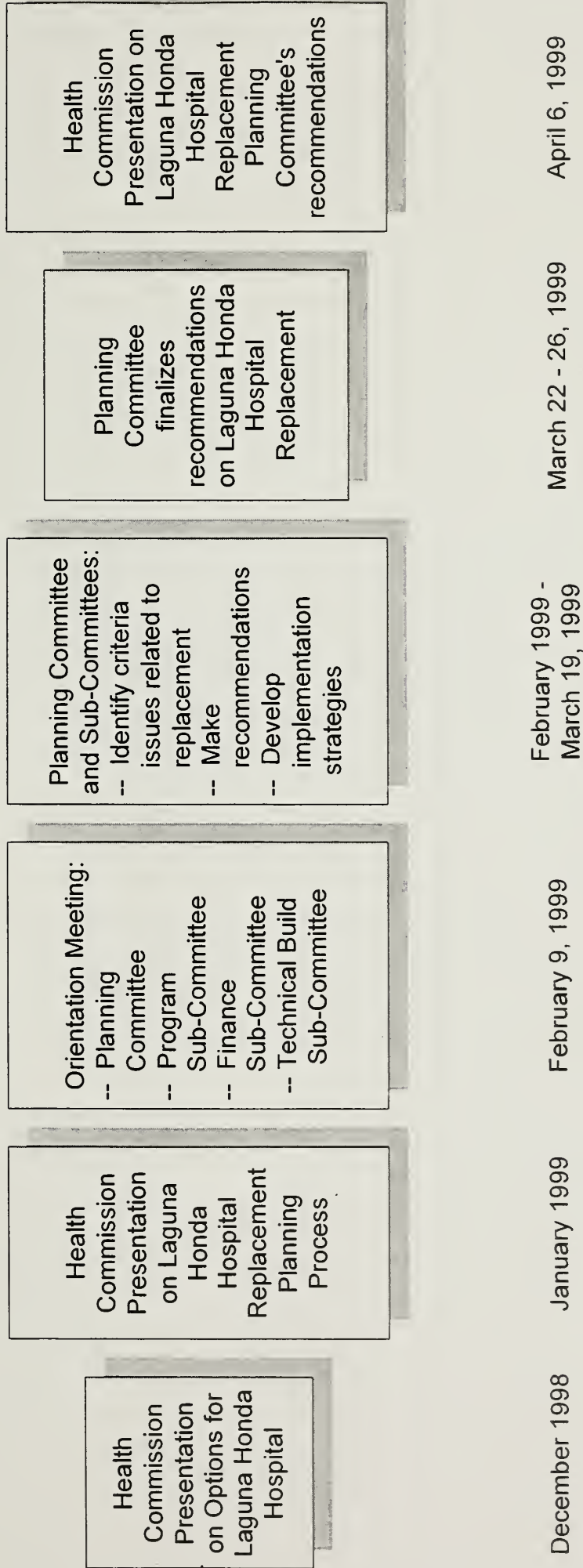








# CITY AND COUNTY OF SAN FRANCISCO LAGUNA HONDA HOSPITAL REPLACEMENT PLANNING PROCESS



The San Francisco Health Commission will receive ongoing updates regarding the progress of this planning effort from the Director of Health prior to the April 6, 1999 presentation.

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Mitchell H. Katz, MD  
Director of Health

## MEMORANDUM

**DATE:** December 10, 1998

**TO:** Honorable Lee Ann Monfredini, President and  
Members, San Francisco Health Commission

**FROM:** Mitchell H. Katz, M.D.  
Director of Health *Mitchell Katz MD*

**RE:** Laguna Honda Hospital

Attached please find a white paper on Laguna Honda Hospital (LHH). The goal of the white paper is to provide a detailed review of the issues facing LHH as well as the policy options regarding its future.

I look forward to a lively discussion on this important issue. If there are any questions prior to the meeting, please contact me.

Thank you.

10.0

Memo 12.10 whitepaper LHH.doc; MK:ph

**OPTIONS FOR  
LAGUNA HONDA HOSPITAL  
WHITE PAPER**

**Mitchell H. Katz, M.D., Director  
Department of Public Health  
December 10, 1998**

10.1

## Executive Summary

This White Paper discusses the current situation at Laguna Honda Hospital and presents the options for rebuilding the institution.

Laguna Honda Hospital is a 1200 bed San Francisco county-run skilled nursing facility (SNF) in the Forest Hills neighborhood. Most Laguna Honda residents require intensive nursing assistance for the activities of daily living: eating, bathing, relieving themselves and dressing. The current average age of a Laguna Honda resident is 72.

The need for long-term care (both community-based and hospital-based) will grow over the next two decades. An estimated 6% of San Franciscans aged 18 – 64 and 23% of San Franciscans over the age of 65 have mobility problems or limitations in caring for themselves. This translates to approximately 57,000 lives in the year 2000. Some of these individuals can be cared for in their homes or in less intensive settings while others will require skilled nursing in institutions such as LHH. By the year 2000 there will be a shortage of 271 SNF beds in San Francisco. Estimates are that this shortage will increase to 2,380 beds by the year 2020 assuming that SNF beds continue to be used at the same rate (i.e., 33 SNF beds for every 1000 persons aged 65 and older). LHH is a critical component of San Francisco's long-term care delivery system.

Although LHH has a well-deserved reputation for providing excellent medical and nursing care, it has been criticized by federal regulators due to the limitations of its physical plant, specifically:

- the principal patient care buildings are 70 to 90 years old and have outlived their useful life,
- LHH's open ward configuration, which accommodates 30 patients in a single room, is not within current federal guidelines which call for housing no more than 4 patients in a single room,
- LHH does not conform to seismic safety standards for hospital construction and was not designed to withstand major earthquakes, and
- needed maintenance has been deferred or under-funded for several years.

The Department has explored several options to ensure that residents have access to needed skilled nursing services. The options are not mutually exclusive and include:

### Options Considered

1. Decrease the number of residents (the census) at LHH.
2. Refurbish existing LHH to conform with 4 bed wards and dining/activity areas.
3. Utilize existing beds at acute care institutions.
4. Build several smaller facilities throughout the City.

5. Sell the land of LHH and locate the facility elsewhere in the City where property values are lower.
6. Sell or rent a portion of the land of LHH to obtain additional revenue.
7. Increase use of community-based long-term care options.
8. Place residents who need long-term care out of county.
9. City phases itself out of the institutional long-term care business.
10. Build a new Laguna Honda Hospital at the current Forest Hills site.
  - 10a. Build a 1200 bed replacement facility.
  - 10b. Build an 800 bed replacement facility.
11. Pursue State and Federal financing to help rebuild LHH.
12. Use Tobacco Settlement Funding to finance rebuilding of LHH.

The advantages and disadvantages of each option are assessed. As outlined in the briefing paper, many of these options are not advantageous because they might result in an unacceptable reduction in the number of skilled nursing beds or are more costly. Based on the projected need for institutional-based long-term care services and the Department's assessment of each option, the following recommendations are made:

#### **Departmental Recommendations**

1. Rebuild LHH on the existing Forest Hills site.
2. Delay seismic upgrade of administrative space until the next city-wide seismic upgrade bond – saving \$38 million from original LHH rebuild scenario.
3. Work collaboratively with City's Long Term Care Pilot Project Task Force to increase home and community-based long-term care services and decrease reliance on institutional placements.
4. Use Tobacco Settlement Funding to rebuild LHH.
5. Pursue Federal & State to help cover the the rebuilding costs.
6. Begin to build a consensus on the right size for a new LHH, by arranging a series of input meetings with interested parties including elders and disabled persons, their advocates and service providers, union leaders, members of the business community, and civic leaders. Feedback will be brought to the Health Commission.



## Options for Laguna Honda Hospital White Paper

Following the decision not to pursue a ballot measure on rebuilding Laguna Honda Hospital (LHH) for November 1998, we have a window of time to reconsider the various options for LHH.

The purpose of this document is to 1) review our current situation with regard to LHH, 2) consider all available options for LHH, and 3) critically review the pros and cons of different options.

### **The current situation of LHH**

LHH is a 1200 bed San Francisco county-run skilled nursing facility (SNF) in the Forest Hills neighborhood. Although it has a well-deserved reputation for providing excellent medical and nursing care to indigent and working class residents of San Francisco, it has been under attack from Federal regulators, specifically the Health Care Financing Administration (HCFA) and the Department of Justice (DOJ) due to the limitations of its physical plant.

### **Physical Plant of LHH**

Laguna Honda Hospital consists of a main building with various wings that house patient care wards and support services, several utility buildings and Clarendon Hall. The principal patient care buildings are 70 to 90 years old. They have outlived their useful lives and cannot cost-effectively accommodate modern health care technologies. Most buildings have not had major upgrades in the last 35 years, although almost all other health care institutions in the Bay Area have undergone several expansions and remodeling projects.

The Hospital's main building is designed with open wards which accommodate 30 patients in a single room. LHH is the last skilled nursing facility in the United States to operate open wards of this size. Current HCFA guidelines call for no more than 4 persons in a room. Thus, to continue the operation of LHH, the Department of Public Health requires a waiver from HCFA. This waiver can be revoked at any time. In the absence of the waiver, we would be unable to bill Medicaid and Medicare, resulting in the loss of \$91 million dollars and making it impossible to continue operation of LHH. HCFA surveyors have been extremely critical of the open ward design of LHH during the 1998 inspections. In their opinion, the open wards deny residents their rights to privacy and dignity. DOJ has also been critical of the large, open wards for failing to afford privacy and for being too noisy such that ill patients cannot get sufficient rest.



In addition to the open wards, there are other important ways that LHH is not in compliance with existing long-term care standards. These standards call for dining halls for residents. Given that most LHH residents are in wheel chairs, such dining halls need to be available on or near the ward where the resident resides. Because LHH was built as an acute care hospital, it was envisioned that residents would be eating at their beds. While there are several large rooms that could be used as dining halls at LHH, the amount of time necessary to move non-ambulatory residents to these large halls is prohibitive. The floor plan at LHH with its long distances between buildings and few elevators, which run slowly, all work against having sufficient staff to move residents to existing halls. HCFA has wanted us to further reduce the census at LHH so as to accommodate dining halls on the wards.

The HCFA surveyors have also criticized LHH for its lack of separate activity areas. This is closely related to the dining hall issues, as most SNF's are built with multipurpose rooms next to the wards that can be used for both dining and therapeutic activities.

### **Seismic issues at LHH**

The main hospital building and Clarendon Hall were not designed to withstand earthquakes and do not conform to seismic safety standards for hospital construction.

The most recent reports on the structural integrity and seismic safety of LHH were produced in 1992 by the Department of Public Works (The Seismic Assessment of Various City Owned Buildings Report). The main hospital building and Clarendon Hall were assigned a seismic hazard rating of "3". A "3" rating is defined as major damage/poor performance – during a major earthquake (Appendix 1). The definition of a "3" rated building also includes "structural and non-structural damages are anticipated which would pose appreciable life hazards to occupants". The building has to be vacated during repairs or possibly cannot be repaired due to the extent and/or economic considerations.

The seismic assessment of the Laguna Honda Hospital patient care buildings describe significant structural deficiencies with sheer walls, roofs and flooring systems, sanitary and elevator towers, partitions made of hollow clay tiles and lack of bracing for ceilings, light fixtures and fire suppression systems.

During the Loma Prieta earthquake, Clarendon Hall sustained major damage in the south wing which required retrofitting for continued safe operation. The main building sustained cracked plaster walls and ceilings, cracked flooring tiles and windows.

### **Maintenance issues at LHH**

The LHH facility shows signs of suffering from decades of deferred maintenance and under funding of maintenance. Laguna Honda has 11 buildings on campus totaling

785,000 square feet. The annual maintenance and repair budget is \$500,000 which is insufficient for a large aging facility with a stockpile of deferred maintenance items.

The Capital Improvement Advisory Committee (CIAC) has provided funding for the highest priority capital improvement projects at Laguna Honda. They currently include a \$1.9 million project for partial replacement of the original roof of the main building and \$356,000 for phase II of the fire safety system replacement. Both of these projects are essential in maintaining the facility adequately to retain licensure.

For the next 5 to 10 years there is a need for an additional \$10 to \$15 million to fund maintenance and repair as well as capital improvement projects for the existing building (6 year capital plan attached as Appendix 2). The required work includes completion of roof replacement and fire safety systems, interior and exterior painting, flooring replacement or repair, upgrades or replacement of elevators, upgrade to mechanical and electrical systems, ADA compliance, and a number of other projects.

The Department of Public Health has also intentionally deferred all major capital improvement projects except those that are essential to the life safety, health and comfort of residents with the intention of advancing the general obligation bond to replace the facility. Unless the facility is replaced an increasing portion of the deferred maintenance items must be funded.

### **Patient Population at LHH**

Most Laguna Honda residents require intensive nursing assistance for the simplest activities of daily living: eating, bathing, relieving themselves (i.e. using the toilet) and dressing. As such, Laguna Honda Hospital is a critical component of San Francisco's long-term care delivery system.

The current average age of a Laguna Honda resident is 72. The average length of stay for individuals residing in the Hospital for less than one year is 75 days; for those remaining in the facility over one year the average length of stay is 5 years. Three-fourths (\$91.5 million) of the Hospital's annual reimbursement comes from Medi-Cal and Medicare which funds institutional long-term care. The remaining reimbursement (\$20 million) comes from private insurance, State Realignment and City and County General Fund.

LHH is a "distinct part" SNF. To be a distinct part SNF, a facility must have either a few acute care beds or operate under the license of an acute care facility.

As a distinct part SNF, LHH receives a higher daily rate from Medicaid (\$234.00) than free-standing SNFs, which receive approximately \$86.00 a day. In exchange for this higher rate, distinct part SNFs are meant to admit "heavy care" patients. These are patients who not only meet the minimum SNF criteria but also have other needs which complicate their care (e.g., substance abuse, mental illness, severe cognitive impairment, behavioral problems, neurological impairment).



The state requires that distinct part SNFs attempt to discharge new patients to lower cost free-standing SNFs during the first 25 days of the patient's placement at Laguna Honda (the Hudman Regulations). Since 1990, after thousands of calls, only one patient has been successfully placed at a free-standing SNF. The reason is that free-standing SNFs do not have sufficient resources to care for complicated patients. In fact, patients are often transferred from these free-standing SNFs to LHH when their care needs become too great to be met at a free-standing facility.

LHH is licensed for a maximum census of 1214 Distinct Part Skilled beds (total census of 1457 including acute care beds). It contains one-third of all skilled nursing beds in San Francisco. The maximum census in fiscal year 1997-98 was 1193. Of Laguna Honda Hospital's operational beds, the vast majority (1027) are devoted to long-term skilled nursing beds. The remainder are distributed as follows: 104 skilled nursing facility beds for hospice/AIDS care and Alzheimer's and related diseases; 20 beds for acute general medicine; 15 for acute rehabilitation.

The census is being gradually lowered from 1192 to approximately 1065 as part of a negotiated settlement with HCFA in order to reduce the occupancy of the open wards, and to create space for separate dining and activity areas. This reduction in census has had a negative impact on institutional long-term care placement in San Francisco. To achieve this reduction in census LHH is currently accepting admissions only from San Francisco General Hospital of patients who have been refused by all other institutions. Since July 1998, we have not been able to admit frail elders who are failing at home or patients from other acute care institutions who need the services of LHH.

Even at its full census, there was a waiting list for entry of patients into LHH. Availability of SNF beds is tight at all institutions in San Francisco. The average occupancy rate of SNF beds in San Francisco is 94%.

### **Finance issues at LHH**

Ninety-five percent of LHH's resident days have Medicaid as their source of reimbursement. Medicaid pays \$234 dollars a day for LHH. The City's cost for LHH is approximately \$280 dollars a day. Thus the Department patches the Medicaid rate by \$46 dollars a day per resident.

### **Projections of need for long term care in San Francisco**

The need for long term care in San Francisco will unquestionably increase in the next three decades. The aging of the "baby boom" generation will markedly increase the numbers of persons over the age of 65, the population most likely to need long term care. According to the State Department of Finance, San Francisco's 65 and over population is expected to increase from 116,080 in 2000 to 129,787 in 2010, and to 181,981 in 2020—

an increase of 57%. Similarly, San Francisco's population of persons 75 and over will increase from 59,523 in 2000 to 66,483 in 2010, and to 75,346 in 2020--an increase of 26%. Our population of persons 85 and over will increase from 17,718 in 2000 to 23,958 in 2010 to 26,832 in 2020--an increase of 50%.

Not all older persons will need long term care. Conversely, some persons under the age of 65 require long term care because of disabilities. The precise number of persons that will require long-term care in San Francisco is difficult to predict. One indicator of demand is the number of persons with mobility or self-care limitations. The U.S. Census Bureau estimates 6% of persons 18 to 64 and 22.9% of persons 65 and over have mobility or self-care limitations. These percentages can be used to project the future mobility or self-care limitations that will be experienced by younger and older adults in the City (Table 1).

**TABLE 1**  
**PROJECTIONS OF MOBILITY OR SELF CARE LIMITATIONS IN**  
**SAN FRANCISCO**

YEAR	Persons 18 to 64	Persons 18 to 64 with mobility or self-care limitations	Persons 65 & Over	Persons 65 & Over with mobility or self-care limitations	TOTAL
2000	506,588	30,395 (6.0%)	116,080	26,582 (22.9%)	56,977
2010	494,877	29,693 (6.0%)	129,787	29,721 (22.9%)	59,414
2020	464,962	27,898 (6.0%)	181,981	41,673 (22.9%)	69,571

Source: U.S. Census Bureau

### **The Demand for Skilled Nursing Facility (SNF) Beds**

SNF beds, such as those provided by LHH, are only one component of long-term care. They are best reserved only for those people who cannot be supported by less institutional care. Persons who can be sustained in their homes or in less intensive settings (e.g., assisted living, service enriched housing, or residential care facilities) should be supported in those settings. Nonetheless, there is a group of individuals who can only be cared for humanely in an institutional setting such as LHH.

DPH recently assessed residents at LHH for the possibility that a sizable proportion could be discharged to a less institutional setting. Assessment teams included experts in community placements. The teams found that there are only approximately 100 residents at LHH who would be appropriate for a less institutional placement. Even for these 100 persons, many of the alternative community placements are not currently available (e.g., psychiatric board and care). It should be noted that the best time to arrange a community placement is prior to placement in a facility like LHH. Once patients are in an institution and have lost their home and/or their ability to cope in a less restrictive environment, community placement becomes significantly more difficult. Nonetheless, this assessment



indicates that the vast majority of residents at LHH need the level of care provided at a skilled nursing facility.

Currently, there are 3,625 SNF beds in San Francisco. Our SNF bed rate in 1995 (the most recent year for which we have calculated this index) was 33 Nursing Facility beds per 1,000 persons over age 65. If we were to continue to use SNF beds at the same rate and maintain LHH at its existing 1200 beds, Table 2, shows, that we will experience an acute and growing shortage of SNF beds in the coming years.

**TABLE 2**  
**PROJECTED SUPPLY AND DEMAND FOR SNF BEDS**

YEAR	2000	2010	2020
Rate per 1000 persons 65 & older	33 SNF beds per 1000	33 SNF beds per 1000	33 SNF beds per 1000
Projected Demand For SNF Beds	3,831	4,282	6,005
Projected Supply	3,625	3,625	3,625
Shortage of Beds	- 271	- 657	- 2,380

However, it should be the goal of the Public Health Department to reduce our reliance on SNF beds. The State of Oregon which has very progressive policies on community placements, has a SNF bed rate of only 27 SNF beds per 1,000 persons over the age of 65 years. (For comparison, the State of Washington has a SNF bed rate of 45 beds per 1,000 persons over the age of 65). However, even if we are successful in decreasing the proportion of persons with long-term care needs who require SNF beds, the absolute numbers of persons who will need SNF beds will increase due to the aging of the population. This is shown in Table 3. By the year 2020, we will have a shortage of SNF beds of 1,288, even if we have reduced our use of SNF beds to only 27 SNF beds per 1000 persons 65 and older.

**TABLE 3**  
**PROJECTED SUPPLY AND DEMAND FOR SNF BEDS**  
(Based on Oregon's experience)

YEAR	2000	2010	2020
Rate per 1000 persons 65 & older	33 SNF beds per 1000	30 SNF beds per 1000	27 SNF beds per 1000
Projected Demand For SNF Beds	3,831	3,894	4,913
Projected Supply	3,625	3,625	3,625
Shortage of Beds	- 271	- 269	-1,288

Thus, the health care needs for San Francisco dictate an increase in SNF beds in the near future.

### **Available options for LHH**

Below are a list of possible options available for LHH. Some of the options can be pursued jointly (e.g., increase the use of community-based alternatives, rebuild LHH, pursue SB 1732 revenue).

#### **1. Decrease the number of residents (the census) at LHH.**

This is the option that is being pursued by HCFA. HCFA staff is not confident that San Francisco will succeed in passing a bond measure. Regardless, they are aware that a new building will take seven years to build and they do not wish to wait for a new facility for us to improve the quality of life of LHH residents.

Unless the City is able to demonstrate that it will be rebuilding LHH, it is likely that HCFA will attempt to force the City to further reduce the size of LHH. Their goal would be to restrict us to a census that would increase the distance between the patient beds on the open ward to satisfy their concern regarding privacy. Markedly decreasing the census at LHH would enable us to provide dining halls and activity areas on the wards.

HCFA has the ability to deny the Public Health Department reimbursement for patient care at LHH. It is very unlikely that HCFA would completely terminate LHH's provider agreement because of the political and ethical ramifications. Moreover, if HCFA were to terminate our provider agreement they state would have to find alternate beds for our residents. Since this would be impossible, it is very unlikely that they will pursue this remedy. On the other hand, HCFA has threatened to cut-off payment for any new admissions. This is a credible threat. If they pursued this, they wouldn't be obligated to identify alternative beds for residents. They would be able to argue that they had not evicted anyone from Laguna.

#### **Pros:**

- 1) A decrease in census may satisfy HCFA & DOJ on this issue.
- 2) Would not require a general obligation bond for LHH.

#### **Cons:**

- 1) Would cause a severe shortage of SNF beds in San Francisco. Would likely result in acute care hospitals being unable to discharge patients who should be transferred to a more appropriate subacute setting. Would result in patients failing at home with no alternative placements available.
- 2) Although a substantial decrease in the LHH census would likely satisfy HCFA and DOJ on this issue, the LHH buildings cannot stand forever. We run the risk of spending large amounts of money to maintain facilities that have outlived their usefulness.

- 3) As we decrease the number of residents at LHH, the operating cost per resident will increase because of the fixed costs of running LHH.
- 4) Would result in a substantial reduction in revenue which could only be compensated through lay-offs or attrition of staff.

## **2. Refurbish existing LHH to conform with four bed wards with dining/activity areas.**

A plan was considered in 1992 to perform an interior renovation of existing patient care wings. Essentially the open wards would be remodeled to 4 bed wards. Because this would be a less economical use of space, the census at LHH would need to be reduced to 720 beds. The cost was \$160 million dollars (when determined in 1992). However, our architects are doubtful that this option is still viable, given new retrofit standards. These standards call for verification of quality and type of steel framework, specific compression strength for concrete, and a variety of other code requirements.

### **Pros:**

- 1) Would satisfy HCFA.
- 2) Would cost substantially less than a new building.

### **Cons:**

- 1) Would cause a severe shortage of SNF beds in SF. Would likely result in acute care hospitals having to keep patients who should be transferred to a more appropriate subacute setting. Would result in patients failing at home with no alternative placements available.
- 2) LHH buildings cannot stand forever. We run the risk of spending a large sum for an interior renovation of facilities that have outlived their usefulness.
- 3) As we decrease the number of residents at LHH, the operating cost per resident increases because of the fixed costs of running LHH.
- 4) Would result in reduction in revenue of \$25-30 million which could only be compensated through lay-offs or attrition of staff.
- 5) Unclear if this option is still viable given new retrofit standards.

## **3. Utilize existing beds at acute care institutions.**

Although there is insufficient acute care bed capacity in San Francisco to completely solve the need for SNF beds in San Francisco, this may be a viable option for a portion of our needs.

A 1997 study by The San Francisco Nursing Facility Bed Study, commissioned by the San Francisco Section of the West Bay Hospital Conference, estimated a total of 271 acute care beds available for potential conversion to SNF as of June 1996. These beds are listed below in Table 4.



**TABLE 4**  
**TOTAL ESTIMATED ACUTE BEDS AVAILABLE FOR CONVERSION TO SNF BEDS**  
**JUNE, 1996**

**Hospital Name**

Chinese Hospital	None
California Pacific Medical Center	None
Kaiser Medical Center	None
Davies Medical Center	80 Beds
San Francisco General Hospital	None
Saint Francis Memorial Hospital	40 Beds
St. Luke's Hospital	40 Beds
St. Mary's Medical Center	32 Beds
UCSF Medical Center/Mount Zion	21 Beds
VA Medical Center	None
Pacific Coast Hospital	18 Beds
Seton Medical Center	36 Beds
<b>TOTALS:</b>	<b>271 Beds</b>

Although we have not formally resurveyed the hospitals, there is reason to believe that there are fewer beds available now than at the time this survey was conducted. Hospitals are running closer to capacity in 1998 than they were in June of 1996. Many hospitals have used existing space for research or physician offices. The largest congregation of beds for conversion was at Davies, which was recently purchased by CPMC. CPMC purchased Davies specifically because it needed more space for its operations.

There are two potential models for using existing acute care beds. The facilities could administer the beds themselves (i.e., hire labor, develop programs) or the Public Health Department could lease the space and staff the beds with city employees, purchasing only "hotel" services (dietary, housekeeping, laundry, supplies).

In terms of the facilities administering the beds themselves, any of these acute care facilities who wished to open SNF beds could have chosen to do so. They would have been able to bill Medicaid at the same distinct part SNF rate of \$234 that the City receives. These facilities have not pursued using their empty beds in this way because they cannot meet their expenses at this rate. Acute care hospitals typically bill private insurers between \$1200-\$1500 a day for their acute care beds (Medicaid rates are lower), so a rate of \$234 is unattractive.

If the City were willing to provide a patch to the Medicaid rate it is likely that other hospitals would become interested in delivering this service, depending on how large the patch is. However, it is unlikely that the existing patch (approximately \$46.00) that the City pays to make up the difference between Medicaid reimbursement and the cost of doing business at LHH would be sufficient.

We have approached several San Francisco hospitals about the possibility of utilizing empty beds at their facility. One San Francisco hospital estimated that its cost of administering SNF beds is approximately \$295.00 dollars a day. Thus they would require a Medicaid patch of \$61 dollars, rather than the current \$46 dollar patch we are using for LHH.

Providing a patch for non-profit hospitals may violate existing City MOU agreements with some of its unions, which have clauses prohibiting contracting out with existing general fund dollars.

Of the \$295 cost per day estimated by this hospital, approximately \$100 dollars represents their cost of "hotel" services. If the hospital were willing to allow us to rent wards within their facility, we could maintain our existing work force (hospital within a hospital model). However, we would incur additional expense. Because of the economies of scale at LHH, we would save very little per person at LHH for each resident relocated to St. Lukes or another facility. While the exact amount that would be saved is difficult to calculate we know it would be markedly less than \$100 per day. Thus, we would need additional revenue to pursue this option. Purchasing only the "hotel" services would likely not violate any City MOU agreements with labor unions.

Assuming that we can identify a group of beds for conversion at acute care hospitals and cover the additional operating costs, we still face the challenge of covering construction costs. The standards for acute care beds are different from the standards for SNF beds. Thus, there are construction costs in converting from acute care to SNF beds. For example, acute care wards generally do not have dining areas on ward, a requirement for SNF beds. When San Francisco General Hospital converted one ward from acute care to SNF, the cost was \$400,000 for converting 30 beds.

**Pros:**

- 1) Purchasing hotel services (hospital in a hospital model) may be a viable option for obtaining a portion of the needed SNF beds.

**Cons:**

- 1) Construction costs may be prohibitive. Also, unless the facility can guarantee the City a long lease, it would be unwise to invest City funds in construction of non-city owned facilities.
- 2) Operating costs would be significantly higher because of the loss of economies of scale of running 1200 beds at LHH.
- 3) Would still require rebuilding of LHH, albeit at a smaller size.
- 4) Patching Medicaid rates to use a contractual staffing model may violate existing City MOU agreements with some of its Unions.

**4. Build several smaller facilities throughout the City.**

There is no question that the trend for long term care is away from single site institutions. Thus, it would be sensible to consider building multiple facilities (for example, building



six two hundred bed institutions throughout the county. This option could allow for residents to be cared for in a setting closer to their own community.

While these are strong programmatic reasons for building several smaller facilities, this option is markedly more expensive. The 1994 Bond report projected the cost of building 12 ninety-nine bed institutions (with location of one facility on the existing site of LHH and including land purchase for the other facilities) was \$653 million dollars in 1994 dollars (compared to \$482 million in 1994 dollars for building a single 1200 bed facility).

The City would also face difficulties in identifying available land for construction. The operating costs of running several smaller facilities would be greater. Finally, it is unclear whether the State would be willing to grant us the higher distinct part SNF rate for 6-12 facilities, each of which may have to maintain some acute beds to qualify for the distinct part SNF rate.

**Pros:**

- 1) Several community-sited facilities is a better programmatic model.
- 2) There would probably be greater support for this option in the community than building a single site facility.

**Cons:**

- 1) Markedly higher constructions cost than building one single site. City may also face obstacles identifying land for the facilities.
- 2) Higher operating costs.
- 3) May not be able to qualify each of the facilities for distinct part SNF rates, thus reducing revenue.

**5. Sell the land of LHH and locate the facility elsewhere in the City where property values are lower.**

LHH sits on a 62 acre parcel in a very desirable residential area of Forest Hills. This raises the question of whether the land could be sold and the revenue used to locate LHH in another area in San Francisco where property values are lower.

In considering the value of LHH land, it is important to note that 50% of the site is zoned as a "greenbelt" and therefore cannot be developed without a zoning variance. Applications for variances to greenbelts have experienced strong opposition from environmental groups and surrounding neighbors.

Assuming that no zoning variance is requested or granted, City Planning staff projected that approximately 400 to 500 units could be built on 50% of the LHH parcel. City Planning estimated that the value of the land assuming no variance was \$20-\$30 million in 1994 dollars.

Although there are areas of the City where property values are lower, this option would result in significant delays in rebuilding LHH. A new site would need to be identified, we

would need to obtain planning approval, develop environmental impact reports, conduct hazardous material abatement, etc. The delay is problematic for two reasons. It would be harder to hold State and Federal regulators at bay, if we are adding two years to the timing of a new building. Also, the construction costs for a new LHH are very sensitive to cost escalations (i.e. inflation) due to delays in building the project. One idea which has been advanced by the architect, Derek Parker, is to relocate the new facilities on top of City owned parking garages. This would save the dollars incurred by having to purchase new land. It is unknown, however, if the existing structures are seismically strong enough to build on and still meet the SNF standards.

**Pros:**

- 1) Selling the land and acquiring a new site for LHH in a neighborhood with lower property values could potentially provide a revenue source for the project. If we prevailed on City Planning to remove the greenbelt determination, the value of the LHH land would be even higher.

**Cons:**

- 1) Identifying a new site and obtaining the necessary approvals to rebuild LHH could result in significant delays to the project
- 2) There would likely be significant neighborhood opposition to selling the LHH land and allowing 400 to 500 units to be developed on the site. Neighborhood opposition would undoubtedly increase if we propose removing the greenbelt designation and building a larger number of units.

**6. Sell or rent a portion of the land of LHH to obtain additional revenue.**

One option, closely related to option 5, is to rebuild LHH at its current site but sell or rent the remaining land. However, with the greenbelt designation, very little land would be available for sale or rent if we rebuilt LHH at the site. The acreage which currently houses Clarendon Hall would be available and could be sold. Potentially, the land of Clarendon Hall could be sold or rented for the sake of providing market rate senior housing or assisted living. This could provide a potential revenue source of LHH. However, at best the available land at LHH could only generate a small portion of the total cost of rebuilding LHH. As discussed in option 5, if we were to pursue revoking the greenbelt designation of LHH, this would increase available land, but at the cost of generating significant neighborhood and environmental opposition.

**Pros:**

- 1) Source of revenue to offset cost of rebuilding LHH.

**Cons:**

- 1) Any large sale or rent of LHH land would likely yield strong neighborhood and environmental opposition.
- 2) Small amount of land would be available for sale and level of revenue from selling land would be marginal unless greenbelt designation is removed.



## **7. Increase use of community-based long-term care options.**

Many persons who need long-term care can be maintained in their homes or in a less institutional setting than LHH. Alternatives to institutionalization include home care, assisted living, board and care, psychiatric board and care, adult day health care, full-continuum program of all-inclusive care for the elderly (PACE model, such as On Lok). Persons who can stay in the community generally prefer to do so. This is especially true of younger disabled persons. Our ability to provide sufficient supports for persons to stay in their homes or community settings depends on available resources as well as creativity in using these resources.

One limitation to community placements has traditionally been the lack of sufficient State and Federal reimbursements for this type of service. For example, Medicaid will pay LHH for a person with skilled nursing needs, but will usually deny paying for a sufficient number of home care hours to allow the person to stay at home. A second problem has been the reluctance of Medicaid to pay for housing, even though loss of housing or lack of handicapped accessible housing often leads to institutionalization (e.g., an elder living at home has a stroke, lives in a third floor walkup without an elevator and, therefore, requires admission to LHH).

It has been suggested by community-based providers that there might be a substantial number of LHH residents who could be cared for at a less institutional facility than LHH. To answer this question, the Department comprehensively evaluated over 700 of the highest functioning residents of LHH. The evaluation team included community-based service providers, so as to broadly consider alternative options for LHH residents. Less than 100 residents were considered candidates for discharge. Among these, the largest group (35) were further assessed to be at the appropriate level of care. Other residents (25) were felt to be candidates for a PACE model. However, none of the residents for whom this was an option wished this placement. Another group of residents (35) were felt to be candidates for medical or psychiatric board and care facilities, which are in extremely short supply. At the conclusion of this process, of all of the patients evaluated, only five were discharged. One important limitation of this evaluation was that the best time for community placement is prior to individuals spending substantial time in a long-term care institution. Once residents have lost their home, community ties and survival skills for living independently, alternative placement is substantially more difficult. Residents at LHH are now and will continue to be assessed for their appropriate level of care prior to and after admission.

To address the need for more community-based long-term care options, San Francisco has been actively planning a Long-term Care Integration Pilot Project as envisioned by AB 1040, signed into law in 1995. The Pilot Project is intended to provide counties with greater flexibility in the design and financing of long-term care services so as to facilitate a greater emphasis on in-home and community-based program models. AB 1040 is based on the assumption that there is a portion of the population currently utilizing institutional long-term care services (such as skilled nursing facilities) that could be cared for in less intensive, non-institutional settings. For some percentage of this population, restrictions

associated with Medi-Cal reimbursement requirements have been identified as obstacles in providing care in these alternative settings. Through AB 1040, San Francisco is seeking waivers so that it may be reimbursed for providing care to some Medi-Cal recipients in non-institutional settings. The Public Health Department is the lead agency for 1040 planning. The members of the Long-Term Care Pilot Project Task Force were appointed by the Board of Supervisors and the Mayor.

San Francisco's long-term care integration plan will improve access to home and community-based long-term care services while simultaneously maintaining access to skilled nursing facilities. Under the plan, persons who need long-term care services will select from a network of providers to receive services. The provider network will be responsible for making sure that clients receive case management, long-term care and acute care services. Under the dictates of AB 1040, San Francisco will designate (or create) a long-term care agency to oversee this new long-term care delivery system. In addition to proposing a new service delivery model, the long-term care integration plan also defines the continuum of home, community and institutional services needed for this population. The success of this plan is dependent upon the availability of supportive housing to keep long-term care consumers in their communities for as long as appropriate. As envisioned, San Francisco will create a capitated managed care system for long-term care services. The Task Force believes that the proposed model will resolve long-standing deficiencies and overlaps in the current long-term care system. The Task Force anticipates that it will take six (6) years to implement this plan.

While the AB 1040 planning shows great promise of creating alternatives to institutionalization, it is clear that there will always be a need for SNF beds. The question is how far can we reduce the need for institutional placements.

In 1995, our use of SNF beds was 33 beds per 1000 persons over the age of 65. If we rebuild Laguna Honda to its current size (1,200 beds) and maintain the same number of total SNF beds in San Francisco (3,625) our use of SNF beds in San Francisco will markedly decrease as the population ages as shown in Table 5.

**TABLE 5**  
**NUMBER OF SNF BEDS IN SAN FRANCISCO**  
**BASED ON LHH BED CAPACITY**

YEAR	PERSONS 65 OR OVER	NO. OF SNF BEDS PER 1000 PERSONS ASSUMING A 1200 BED LHH (3,625 SNF BEDS CITYWIDE)	NO. OF SNF BEDS PER 1000 PERSONS ASSUMING AN 800 BED LHH (3,625 SNF BEDS CITYWIDE)
1995	109,848	33	29
2000	116,080	32	28
2010	129,787	28	25
2020	181,981	20	18



Column 4 shows what our use of SNF beds would be if we lowered our SNF beds at LHH to only 800 beds (for a total of 3,225 beds in San Francisco). It seems unlikely that San Francisco can decrease our SNF bed use from 33 beds per 1000 to only 18 beds per 1000 in the next 20 year period.

Although the data convincingly show the need for SNF beds in the future, it is certainly true that funding for long-term care is scarce. While San Francisco currently has almost enough SNF beds, we are woefully under capacity for community alternatives. Thus, one could consider reprioritizing our resources such that in the future we would be under capacity for SNF beds and have sufficient capacity for community placements. One advantage of this strategy is that since community placements may be cheaper, a reprioritization may result in serving more people.

In the AB 1040 process, one of the major concerns has been that rebuilding all 1200 beds at LHH will deplete all of the City's resources for long-term care. The concern is fueled by the fact that Medicaid rates for SNF's have been frozen for many years. Since the City's costs increase every year, the lack of increase of reimbursement means that the City's contribution to LHH increases every year. Alternatively, if the City were to rebuild only 800 beds, community advocates hope the operating funds (both Medicaid and local funds) for running the additional 400 beds would be used for community placements.

On the other hand, the Public Health Department has traditionally prioritized those at greatest need when funding is scarce. The residents of LHH are the most vulnerable of the population needing long-term care (e.g., those with substance abuse, mental illness, or severe cognitive impairment). Failing to provide for them could lead to unnecessary emergency room visits, unnecessary acute hospital stays, unnecessarily prolonged hospital stays (because of an inability to discharge patients) and an increased number of severely impaired persons living on the streets, in shelters and single room occupancy hotels. When hospitals cannot discharge patients to SNFs, they are unable to admit new patients, resulting in a dangerous shortage of acute care beds. The City also receives markedly less reimbursement when a Medicaid patient who can be discharged is left in an acute hospital bed (@ \$234 a day) compared to the reimbursement for an acute patient (@ \$800 a day for Medicaid; higher for Medicare or private insurance).

In this regard it is important to note that whereas LHH is a more restrictive environment than home care or assisted living, it is a less restrictive environment than acute hospitals, which have no activities, no social dining, etc. Thus it is important to recognize the unique role of LHH in providing rehabilitative and convalescent services.

Pros:

- 1) Community-based alternatives are overwhelmingly preferred by persons who can thrive in non-institutional settings.
- 2) Community-based alternatives may be less expensive and thus a larger number of persons may be served for the same amount of money.



Cons:

- 1) Community-based alternatives are not as successful for the most vulnerably ill persons with long-term care needs.

**8. Place residents who need long-term care out of county.**

Because of the high property values in San Francisco, it is less profitable to build SNF beds within the City than outside the City. However, the number of SNF beds available even outside our county is small.

Medical Social Services at San Francisco General Hospital does a daily computerized search for SNF beds in the 9 bay area counties (Alameda, Contra Costa, Santa Clara, San Mateo, Napa, Sonoma, San Francisco, Solano, Marin) through the PRN system. It searches 166 SNF facilities.

On 9/3/98, 110 SNFs had a total of 279 beds available. When queried on availability of MediCal beds the number was reduced to 49 facilities with 62 beds. When queried on availability of MediCal beds for patients with behavioral problems there were no beds available.

San Francisco General Hospital was trying to place 19 patients on 9/3/98. The system matches beds to patients' medical, psychiatric, behavioral and financial criteria. For these 19 patients, the system came up with the following:

- 7 patients did not match and could not be placed in any of the facilities.
- 12 patients could be evaluated for 11 available slots.

A follow-up of these 12 patients, one week later, revealed:

- 2 were admitted to LHH.
- 2 became medically unstable and are still at SFGH.
- 1 improved and was discharged home.
- 1 was discharged to an AIDS residence.
- 1 was discharged to a free-standing nursing home in San Francisco.
- 5 were awaiting beds to become available in a SNF or other facility.

Overall the City cannot depend on facilities in other counties to house many potential LHH residents.

Pros:

- 1) To the extent that beds are available, we can place San Francisco residents who need long-term care outside of county at no cost to the City.

Cons:

- 1) Few beds are available.

- 2) The goal of maintaining family involvement is hampered when long-term care residents are placed in SNF out-of-county placements.

## 9. City phases itself out of the institutional long-term care business.

Although San Francisco has a proud tradition of providing long-term care, not all counties provide institutional long-term care. Therefore, it is worth asking whether the county should continue running an institution like Laguna Honda Hospital (LHH).

In counties of California that do not have SNFs like LHH, patients needing institutional care are provided for at free standing SNFs or at acute hospital based distinct-part SNFs.

As discussed in Option 3, other acute hospitals in San Francisco could have developed distinct part SNFs and received the same level of reimbursement as the Department of Public Health does. However, hospitals have not pursued this option because Medicaid revenues do not adequately reimburse the costs of institutional care given the cost of doing business in San Francisco.

It is possible that if the City were willing to provide a patch to Medicaid rates other institutions would become interested. However, as was discussed in Option 3, there are few acute beds available for transition to SNF care. It is unlikely non-profit hospitals would be interested in building new facilities for the City unless the City would guarantee multi-year operating costs. Generally, the City does not guarantee operating costs beyond a single fiscal year. A private developer unassociated with a hospital would be unable to bill Medicaid at a distinct-part SNF level, and would therefore receive only about \$90 per resident day. A private developer would also likely want the City to make a long-term commitment to providing an operating subsidy.

It should also be noted that contracting out long-term care services would be a violation of some of our existing labor MOUs.

San Francisco's need for a SNF facility like LHH is also greater than that of other counties. San Francisco has on average an older population than that of other California counties. San Francisco also has a larger population affected by substance abuse, mental illness, and homelessness. When persons with these problems develop medical illness they cannot usually be handled by free-standing SNF and instead require a facility like LHH.

For these reasons, the Department does not recommend this option.

### Pros:

- 1) Would take advantage of the ingenuity of private non-profit providers and private developers.

### Cons:

- 1) Would require a City patch to Medicaid rates.



- 2) Unlikely that non-profit hospitals or private developers would be willing to invest in building new facilities unless the City guaranteed multi-year subsidies.
- 3) Would violate some of the City's MOU agreements with labor.

#### **10. Build a new Laguna Honda Hospital at the current Forest Hills site.**

Thus far, we have primarily explored two options for rebuilding LHH: a 1200 and an 800 bed replacement facility. These options are discussed individually.

##### **10a. Build a 1200 bed replacement facility.**

LHH is currently licensed at 1457 beds, including 1214 Distinct-part SNF beds. Our peak census in 1997-98 fiscal year was 1193. As of November 1, 1998 we are at a census of 1080, due to the moratorium we instituted as a compromise with HCFA. The current moratorium has created hardship for individuals who have not been able to enter LHH (e.g., seniors failing at home). The moratorium has also created problems for acute care hospitals who have had patients for whom they have had no site of discharge.

The projections for long term care in San Francisco discussed above indicate that San Francisco is likely to experience increased demand for SNF beds in the next twenty years. Even assuming we fully rebuild the 1200 beds at LHH we are still likely to experience a shortage in SNF beds.

The bond measure for LHH that was proposed for November 1998 was to cost a total of \$503 million. If this same plan were to go forward in a June 1999 ballot, the cost would be \$529 million because of cost escalation (i.e., inflation) and because there would be a delay due not being able to start excavation in winter (Appendix 3, Option A).

The Department of Public Health has worked with the Bureau of Architecture to decrease the total cost of the program. We have developed two recommendations to decrease the cost of rebuilding the 1200 bed facility from \$529 million to \$434 million: delay seismic upgrade of the administrative space and involve a private developer in demolishing Clarendon Hall and building elder housing or assisted living (Appendix 3, Option B).

We are not required by Federal or State regulations to seismically upgrade the administrative space of LHH. While ultimately this upgrade needs to be performed, we could delay the upgrade until the City pursues a bond measure for seismic upgrading of other City buildings. This would save \$38 million.

In the bond plan for November 1998 we envisioned the City renovating Clarendon Hall. However, it would likely be more cost effective to engage a private developer to demolish and rebuild or renovate the existing facility. This would save \$56 million.

At a total cost of \$434 million, the cost per bed is \$362K. However, to make comparisons with the construction costs at other facilities, the Bureau of Architecture has developed unit costs per square foot. This allows for "apples-to-apples" comparisons. As shown in

Appendix 4, the range of costs per square foot was \$250-\$276. The cost per square foot for the \$503 million LHH rebuild proposed for November 1998 was \$261.00. This clearly falls within the established range. We have not yet recalculated the costs per square footage for this less expensive 1200 bed facility, but we are certain it will fall within the same range.

As the last decade of planning for rebuilding LHH has shown, it is extremely difficult to plan and finance building a facility like LHH. We will likely have only one shot at rebuilding LHH. Whatever facility we choose will have to meet our needs for the next 60 years.

Operating costs must also be figured in to our decision on how large a LHH facility to build. In recent years the size of the gap between Medicaid reimbursement and our expenses, which is the cost to the City General Fund, has grown. The reason the gap has grown is that our expenses have increased both due to inflation and increased staffing requirements of HCFA, while Medicaid reimbursement rates have been flat for five years. This trend is likely to continue.

In this fiscal year LHH is projecting a new \$7 million revenue shortfall. The revenue is decreased because of the moratorium on new admissions. We cannot decrease our staff to compensate for the smaller number of patients because HCFA requires that we provide increased supervision of residents, increased social activities (necessitating hiring additional activity therapists) and social dining experiences for all our residents. Social dining is very labor intensive because it requires getting patients out of bed, transporting them to the dining areas several times a day and then back to their beds or activity areas. Whereas our expenses are increasing, prospects of an increase in reimbursements are not good. The State of California, as well as the Federal government are looking for ways to decrease Medicaid expenses.

**Pros:**

- 1) The projections show that San Francisco will need at least 1200 NF beds at LHH.
- 2) Because there are fixed capital costs in building a new LHH (e.g., power plant, excavation of site), the cost per bed for 1200 beds is less (\$362K) than if we build 800 beds (\$474K).

**Cons:**

- 1) The capital costs of building 1200 beds is high (434 million).
- 2) Maintenance of the 1200 beds at LHH would mean that there would be fewer operating dollars that could be used for community-based alternatives.
- 3) If current trends continue, LHH will need steadily increasing general fund to meet its expenses.

**10b. Build an 800 bed replacement facility.**



Although there is nothing magic about the number 800, we have used this figure in projecting the implications of building a smaller LHH. An 800 bed facility would cost \$379 million dollars (Appendix 3, Option C). The cost per bed (including all costs) would be \$473K.

**Pros:**

- 1) The capital costs of constructing an 800 bed facility are significantly lower than for a 1200 bed facility.
- 2) A decrease in the number of LHH beds would increase the amount of money that could be used for non-institutional community placements (e.g., assisted living which formerly were used for institutional care for alternative community programs
- 3) A decrease in the number of LHH beds would decrease the funding needed from the general fund.

**Cons:**

- 1) An 800 bed facility would not meet the City's needs for SNF beds over the next two decades.
- 2) The cost per bed is higher with an 800 bed facility because of the fixed costs of construction.

# **11. Pursue State and Federal financing to help rebuild LHH.**

We believe it may be possible to obtain State or Federal funding to help rebuild LHH. For example, SB 1732 (Welfare and Institutions Code 14085.5) allows disproportionate share hospitals to finance all or a portion of their capital projects with federal disproportionate share funds (DSH). The funds are above and beyond DSH dollars that the hospital would receive for clinical care. The Department used SB 1732 to finance a portion of the garage for San Francisco General Hospital.

Several counties have used SB 1732 to fund hospital construction (i.e., Contra Costa, Alameda, San Joaquin, San Mateo, etc.) The legislation indicates that the projects coming under SB 1732 must have been approved by the State prior to June 30, 1994. Nonetheless, it is possible to petition the State Legislature to reopen SB 1732.

SB 1732 funding is only available to DSH hospitals. LHH is not a DSH hospital because of the small number of acute care days at LHH. SFGH is a DSH hospital. Therefore, we would need to apply on behalf of SFGH to build a new SNF that would operate under the license of SFGH. We would demonstrate the need for SFGH to build such a facility by explaining that LHH would be closing when construction is complete for the new facility.

The mechanism of reimbursement for DSH would be for the county to float a revenue bond to pay for the construction of the facility. SB 1732 then can be used to pay up to the percentage of the amortized rate (over the 30 year period of the bond) equal to the percentage of Medicaid clients in the institution. At the current time, over 60% of the clients of SFGH have Medicaid. In addition, we are working with the San Francisco

delegation to determine if a specific State appropriation can be made to assist in rebuilding LHH.

Also, Senator Feinstein and Congresswoman Pelosi were successful in adding language to 1999 omnibus appropriation agreement asking the Federal Department of Health and Human Services to assist San Francisco in finding funds to rebuild LHH>.

**Pros:**

- 1) Provides a potential additional revenue source for rebuilding LHH.

**Cons:**

- 1) SB 1732 has expired and State legislative action will be required to allow the City to use this option.
- 2) It may be difficult to obtain a specific appropriation for San Francisco.

## **12. Use Tobacco Settlement Funding to finance rebuilding LHH.**

A settlement between the tobacco companies and the State Attorneys General will bring substantial funding to San Francisco. San Francisco was the first local government to sue the tobacco companies. Because of this, our City Attorney, Louise Renne successfully negotiated for the State of California to share the proceeds of the Brown settlement with local counties. One purpose of the suit was for State and local Health Departments to recoup the cost of health care provided to persons suffering ill health due to tobacco consumption. Recognizing this purpose and the tremendous need to rebuild LHH, City Attorney Renne recommended to Mayor Brown that the settlement be used towards rebuilding LHH. He has agreed to this proposal and with the support of the Board of Supervisors, the funding could be used for this purpose.

The funding itself has no restrictions. It will be a yearly payment to the City commencing in the year 2000. Because the amount of the yearly payment is keyed to tobacco sales as well as inflation, we do not know the exact amount of the payment. Currently the tobacco industry projects that tobacco sales will decline by 3%. However, the settlement also provides for increased payments annually by the CPI or 3%, whichever is greater. These assumptions would yield an approximate payment of \$20-22 million per year in 1999 dollars (appendix 5). However, if tobacco sales decline further due to the increased cost of cigarettes (the tobacco companies are increasing the price of cigarettes to pay for the settlement) the size of the award will shrink. We are currently attempting to estimate the correct asset value of the settlement.

## **PUBLIC HEALTH DEPARTMENT RECOMMENDATIONS:**

1. Rebuild LHH on the existing Forest Hills site.
2. Delay seismic upgrade of administrative space until the next city-wide seismic upgrade bond – saving \$38 million from original LHH rebuild scenario.

3. Work collaboratively with City's Long Term Care Pilot Project Task Force to increase home and community-based long-term care services and decrease reliance on institutional placements.
4. Use Tobacco Settlement Funding to rebuild LHH.
5. Pursue Federal & State to help cover the rebuilding costs.
6. Begin to build a consensus on the right size for a new LHH, by arranging a series of input meetings with interested parties including elders and disabled persons, their advocates and service providers, union leaders, members of the business community, and civic leaders. Feedback will be brought to the Health Commission.



TABLE 1.4.2  
City of San Francisco Seismic Hazard Ratings  
(Source: San Francisco Department of Public Works)

The Seismic Hazard Rating (SHR) is a number assigned to a building as a means of estimating building performance during a great earthquake as well as the amount of damage the building will sustain. The ratings, and the policy implications, are described here:

SHR	Damage Estimate	Description
1	Minor damage (Good performance)	Some structural or non-structural damage and/or falling hazards may occur, but these would pose minimal life hazards to occupants. The damage can be repaired while the building is occupied and with minimum disruption to functions. Buildings and structures with this rating represent an acceptable level of earthquake safety, and funds need not be spent to improve their seismic resistance to gain greater life safety.
2	Moderate damage (Fair performance)	Structural and non-structural damage and/or falling hazards are anticipated which would pose low life hazards to occupants. The damage can be repaired while the building is occupied. Buildings and structures with this rating will be given a low priority for expenditures to improve seismic performance and/or falling hazards to the "good performance" level.
3	Major damage (Poor performance)	Structural and non-structural damages are anticipated which would pose appreciable life hazards to occupants. The building has to be vacated during repairs, or possibly cannot be repaired due to the extent (sic) and/or economic considerations. Buildings and structures with this rating will be given a high priority for expenditures to improve seismic performance and/or falling hazards to the "good performance" level, or would be considered for other abatement programs such as reduction of occupancy.
4	Partial/total collapse (Very poor performance)	Extensive structural and non-structural damage, potential structural collapse and/or falling hazards are anticipated which would pose high life hazards to occupants. There is a good likelihood that damage repairs would not be feasible. Buildings and structures with this rating will be given the highest priority for expenditures to improve seismic performance and/or falling hazards to the "good performance" level, or would be considered for other abatement programs such as reduction of occupancy or vacation.

## APPENDIX 2

### COMMUNITY HEALTH NETWORK LAGUNA HONDA HOSPITAL

#### FY 98-99 CAPITAL IMPROVEMENT REQUESTS (Includes all 6 Year Capital Plan Projects)

Project	*Estimated Costs	
	<u>Subtotal</u>	<u>Total</u>
1. Replace Roof on Main Hospital Bldgs		
Phase I – Patient Service Wings	\$ 1,901,325	
Phase I – Support Service Wings	1,279,129	
Project Total:		\$ 3,180,454
2. Replace Fire Safety System (HCFA Waiver)		
Phase I – Infrastructure	\$ 356,425	
Phase II – System Installation	1,049,452	
Phase III – System Installation	992,684	
Project Total:		\$ 2,398,561
3. Miscellaneous Facilities Maintenance		950,000
4. Interior Renovations in Patient wards (6)		600,000
(DOJ Issue)		
5. Upgrade Existing Telephone Switch		500,000
6. ADA Toilet for Adult Day Health Center		100,000
7. Resident Smoking Pavilions		275,000
8. Replace Kitchen Waste Lines		110,000
9. Patient Ward Interior Painting		190,000
10. Patient Ward Flooring Replacement		65,000
11. Main Building Elevator Repairs		522,500
12. Adult Day Care Renovation		125,000
13. Remodel & Equip Radiology Department		450,000
14. Exterior Repair & Painting of Main Building (Phase I)		575,000
(Total for this project is \$3,715,000)		
15. Misc. ADA Improvements to Main Building		100,000
16. Clarendon Hall Window Sash Repair & Painting		225,000
17. Clarendon Hall Ward Flooring		760,000
18. Patient Tubs/Shower Installation		125,000
19. Woodside Access Road Expansion		100,000
20. Exterior Preservation – Service Buildings		140,000
21. Resurfacing Campus Roadways		300,000
22. Patient Activity Center Remodeling		400,000
Total:		<u>\$12,191,515</u>

\* To be verified/updated by DPW

APPENDIX 3

**COST OF VARIOUS OPTIONS FOR REBUILDING LAGUNA HONDA HOSPITAL**

**OPTION A**

**(As proposed for November, 1998 Bond Measure & updated to reflect delay in implementation)  
1200 BEDS, CLARENDON HALL & ADMINISTRATION RETROFIT**

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1. Demolish power plant and build new Central Plant/Laundry	\$ 37,204,859
2. New 1200 bed hospital & support services	347,346,568
3. Renovate 160 bed Clarendon Hall	56,164,000
4. Seismically upgrade office space in Former hospital	46,248,231
5. Abate & demolish former hospital wards site work	<u>37,058,050</u>
	\$ 524,021,708
Estimate public financing at 1%	<u>5,240,217</u>
	\$ 529,261,295

530

**OPTION B**

**1200 BEDS, NO RETROFIT OF CLARENDON HALL, UPGRADE ONLY ELECTRICAL  
SYSTEMS AND COMPUTER HOOK-UPS OF ADMINISTRATION BUILDING**

---

1. Demolish power plant and build new Central Plant/Laundry	\$ 37,204,859
2. New 1200 bed hospital & support services	347,346,568
3. Upgrade of Administration area	7,882,875
4. Abate & demolish former hospital wards site work	<u>37,058,050</u>
	\$ 429,492,352
Estimate public financing at 1%	<u>4,294,924</u>
	\$ 433,787,276



**OPTION C****800 BEDS, REST IS SAME AS OPTION B**

---

1. Demolish power plant and build new Central Plant/Laundry	\$ 37,204,859
2. New 800 bed hospital & support services	293,356,732
3. Upgrade of Administration area	7,882,875
4. Abate & demolish former hospital wards site work	<u>37,058,050</u>
	\$ 375,502,516

Estimate public financing at 1%

3,755,025  
\$ 379,257,541

\$ 382

Each element includes associated soft cost and escalation to midpoint of construction (4.5% per year). Costs are broad estimates and included as an order of magnitude comparison with other options only.

APPENDIX 2

**COMMUNITY HEALTH NETWORK  
LAGUNA HONDA HOSPITAL**

**FY 98-99 CAPITAL IMPROVEMENT REQUESTS  
(Includes all 6 Year Capital Plan Projects)**

Project	*Estimated Costs	
	<u>Subtotal</u>	<u>Total</u>
1. Replace Roof on Main Hospital Bldgs		
Phase I – Patient Service Wings	\$ 1,901,325	
Phase I – Support Service Wings	1,279,129	
Project Total:		\$ 3,180,454
2. Replace Fire Safety System (HCFA Waiver)		
Phase I – Infrastructure	\$ 356,425	
Phase II – System Installation	1,049,452	
Phase III – System Installation	992,684	
Project Total:		\$ 2,398,561
3. Miscellaneous Facilities Maintenance		950,000
4. Interior Renovations in Patient wards (6)		600,000
(DOJ Issue)		
5. Upgrade Existing Telephone Switch		500,000
6. ADA Toilet for Adult Day Health Center		100,000
7. Resident Smoking Pavilions		275,000
8. Replace Kitchen Waste Lines		110,000
9. Patient Ward Interior Painting		190,000
10. Patient Ward Flooring Replacement		65,000
11. Main Building Elevator Repairs		522,500
12. Adult Day Care Renovation		125,000
13. Remodel & Equip Radiology Department		450,000
14. Exterior Repair & Painting of Main Building (Phase I)		575,000
(Total for this project is \$3,715,000)		
15. Misc. ADA Improvements to Main Building		100,000
16. Clarendon Hall Window Sash Repair & Painting		225,000
17. Clarendon Hall Ward Flooring		760,000
18. Patient Tubs/Shower Installation		125,000
19. Woodside Access Road Expansion		100,000
20. Exterior Preservation – Service Buildings		140,000
21. Resurfacing Campus Roadways		300,000
22. Patient Activity Center Remodeling		400,000
<b>Total:</b>		<b>\$12,191,515</b>

\* To be verified/updated by DPW



APPENDIX 4



(415) 557-4700  
FAX (415) 557-4701  
<http://www.sfdpw.com>

Department of Public Works  
Bureau of Architecture  
30 Van Ness Avenue, Suite 4100  
San Francisco, CA 94102-6020

Willie Lewis Brown, Jr., Mayor  
Mark A. Primeau, AIA, Director and City Architect

Tara D. Lamont, AIA, Bureau Manager

July 29, 1998

Mr. Lawrence J. Funk  
Executive Administrator  
Laguna Honda Hospital  
375 Laguna Honda Blvd  
San Francisco, CA 94116

**Subject: Laguna Honda Hospital Replacement Plan**

Dear Mr. Funk:

Attached is a construction cost comparison of other Hospital facilities to your proposed 1,360 bed skilled nursing facility. These comparisons were derived in conjunction with our consultants Kaplan McLaughlin Diaz and Hanscomb Inc. Not included in any of the unit costs are site and owner specific costs, which vary greatly from hospital to hospital. These include:

- Site work (includes demolition of existing buildings and associated asbestos abatement, preparation of site, roads, new or altered site utilities)
- Furniture and moveable equipment (includes telephones, computers, televisions; carts; hospital beds)
- Equipment typically supplied by the Owner (such as telephone and data wiring and switches, vendor supplied equipment such as laundry & waste management, medical equipment, some food service equipment)
- Owner's special programs (such as Art Enrichment)
- Owner's costs (such as operations, management, legal services; financial services & costs, insurances, permits, fees)
- Non-construction costs (such as design & engineering services, special inspections, testing, owner furnished data, construction management)

Although there is no functionally similar facility, we are able to compare with large, recently constructed acute care institutions. We have adjusted the construction costs for year completed (revised to today's dollar value), location built, and degree of difficulty as compared to your SNF (acute care vs. SNF, small facility vs. large institution, public sector vs. private sector, whether the facility was oversized for future expansion, etc.). We are comparing construction costs on a square foot basis which more closely approximates an apples-to-apples comparison than a per bed cost.

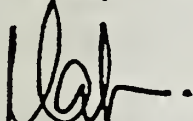


Mr. Lawrence J. Funk  
07/30/98  
Page 2

The program cost of \$502.5 million represents the most cost effective, practical solution for this type of institution on this site. Included in the complete program cost are items we as a City cannot avoid, such as historic preservation of the original Historically Significant hospital, demolition of existing buildings to clear the site, hazardous materials removal, upgrading site utilities, the Art Enrichment program, and interim relocations. We continue to look for further cost efficiencies. For instance, if it proves to be more practical to create 160 beds in the new facility than at Clarendon, we will recommend this option. The beauty of our plan is that it allows for this flexibility.

In summary, we believe our work since 1990 has revealed a Master Plan that creates construction sites for many different health care modalities, retains the character of the original Laguna Honda Home, and allows room for expansion in the future. Our goal is to maintain this flexibility throughout your current program to replace Laguna Honda Hospital.

Sincerely,



Marilyn M. Thompson  
Senior Architect

cc: Anthony G. Wagner, Executive Administrator, CHN  
Tara Lamont, Bureau Manager, BOA  
Mike Stinetorf, KMD

# LAGUNA HONDA HOSPITAL - REPLACEMENT PROJECT

## CONSTRUCTION COST - HOSPITAL COMPARISON

KMD / GHC&P  
29-Jul-98

COMPARABLE HOSPITAL	BID COST BLDG. AREA UNIT COST	TIME ADJUSTMENT	LOCATION ADJUSTMENT	DEGREE OF DIFFICULTY	TOTAL ADJUSTED CONSTRUCTION COST WITH CONTINGENCY
HOSPITAL #1 URBAN CO. HOSP. 464 BEDS FULL SERVICE ACUTE	\$318,000,000 1,292,000 \$246	0.93 \$229	1.25 \$286	0.92 \$263	1.05 \$276
HOSPITAL #2 CA. HMO HOSPITAL 331 BEDS FULL SERVICE ACUTE CENTRAL PLANT	\$102,210,000 557,000 \$184	1.20 \$220	1.15 \$253	0.95 \$241	1.05 \$253
HOSPITAL #3 BAY AREA HMO HOSPITAL 100 BEDS ANCILLARY SERVICES CENTRAL PLANT	\$61,640,000 259,000 \$238	1.00 \$238	1.00 \$238	1.00 \$238	1.00 \$250
HOSPITAL #4 BAY AREA CO. HOSPITAL 153 BEDS ANCILLARY SERVICES CENTRAL PLANT	\$88,760,000 317,000 \$280	1.07 \$300	1.00 \$300	0.92 \$276	1.00 \$276
HOSPITAL #5 GOVERNMENT HOSP. 198 BEDS FULL SERVICE ACUTE CENTRAL PLANT	\$117,400,000 639,000 \$184	1.20 \$220	1.00 \$220	1.08 \$238	1.05 \$250

# LAGUNA HONDA HOSPITAL - REPLACEMENT PROJECT

## CONSTRUCTION COST SCENARIO

( Costs subject to modification as program is refined )

KMD / GHC&P

29-Jul-98

PROJECT	SQ. FT.	COST/SQ. FT.	CONSTRUCTION COST	TOTAL CONSTRUCTION COST
<b>1. New Central Plant</b>				
NEW CENTRAL PLANT	25,000	\$640	\$16,000,000	
ASBESTOS ABATEMENT			\$0	
DEMOLISH (E) PLANT & MISC. STRUCT.			\$0	
	25,000			\$16,000,000
<b>2. New SNF Hospital - 1200 Beds</b>				
NEW CONSTRUCTION				
Patient Care Areas	621,875	\$265	\$164,796,875	
Patient Support	100,492	\$255	\$25,625,460	
Administrative Areas	48,332	\$205	\$9,908,060	
Tele. / Data System			\$0	
ART ENRICHMENT (2%)			\$0	
SITE DEVELOPMENT			\$0	
	770,699			\$200,330,395
<b>3. Renovate Clarendon Hall - 160 Beds</b>				
ASBESTOS ABATEMENT			\$2,200,000	
SEISMIC RETROFIT	113,000	\$60	\$6,780,000	
REMODEL	113,000	\$170	\$19,210,000	
TELE. / DATA SYSTEM			\$0	
	113,000			\$28,190,000
<b>4. Renovate Former Hospital Building for Support / Administration</b>				
REMODEL CONSTRUCTION				
Asbestos Abatement			\$0	
Seismic / Historical Retrofit	0	\$60	\$0	
Remodel (asb./seis./hist./remodel)	101,191	\$185	\$18,720,335	
Tele. / Data System			\$0	
SITE DEVELOPMENT			\$0	
DEMOLISH OLD WINGS			\$0	
	101,191			\$18,720,335

Project Area Total

1,009,890

Construction Cost Total

\$263,240,730

Costhd3

Project Unit Cost

10-3  
444 < \$261 >



# APPENDIX 5

County	1990 Census Pop	% Pop	County Share	City Share	Total Share	Total Payroll All counties all years	1998	2000	2001	2002	2003	2004-2007 per year	2008-2017 per year	2018-2025 per year
Alameda	1,278,182	0.042863	0.036655	0.036655	0.036655	483,698	5,926	15,830	17,094	20,524	20,719	17,282	17,635	19,761
Alpine	1,113	0.000037	0.000034	0.000034	0.000034	421	5	14	15	18	18	15	15	17
Amador	30,038	0.001009	0.000806	0.000806	0.000806	11,359	139	372	401	482	487	406	414	464
Butte	182,120	0.006120	0.005508	0.005508	0.005508	68,865	844	2,254	2,434	2,922	2,950	2,462	2,511	2,813
Calaveras	31,996	0.001075	0.000958	0.000958	0.000958	12,083	148	386	428	513	518	441	494	451
Colusa	16,275	0.000547	0.000492	0.000492	0.000492	6,154	75	201	217	261	264	220	224	251
Contra Costa	803,732	0.027007	0.024306	0.024306	0.024306	303,915	3,723	9,946	10,740	12,896	13,016	10,866	11,080	12,416
Del Norte	23,460	0.000788	0.000709	0.000709	0.000709	8,871	109	290	313	376	380	317	323	362
El Dorado	125,995	0.004234	0.003810	0.003810	0.003810	47,642	584	1,568	1,884	2,022	2,041	1,703	1,737	1,946
Fresno	667,490	0.022428	0.020186	0.020186	0.020186	282,398	3,092	8,260	8,920	10,710	10,811	9,023	9,202	10,311
Glenn	24,798	0.000833	0.000750	0.000750	0.000750	9,377	115	307	331	396	402	335	342	383
Humboldt	119,118	0.004003	0.003602	0.003602	0.003602	45,042	562	1,474	1,592	1,911	1,929	1,610	1,642	1,840
Imperial	109,303	0.003673	0.003308	0.003308	0.003308	6,913	85	228	244	293	286	247	252	289
Inyo	18,281	0.000814	0.000653	0.000653	0.000653	41,331	506	1,353	1,461	1,754	1,770	1,478	1,507	1,689
Kern	543,477	0.018262	0.016436	0.016436	0.016436	205,605	2,517	6,725	7,262	8,720	8,803	7,347	7,482	8,396
Kings	101,469	0.003410	0.003069	0.003069	0.003069	38,388	470	1,256	1,356	1,628	1,643	1,372	1,399	1,567
Lake	50,631	0.001701	0.001531	0.001531	0.001531	19,145	235	627	677	812	820	684	698	782
Lassen	27,588	0.000927	0.000835	0.000835	0.000835	10,436	128	342	369	443	447	373	380	426
Los Angeles Only	8,863,164	0.287821	0.268039	0.268039	0.268039	3,361,422	41,055	109,681	118,437	142,209	143,554	119,812	122,189	136,916
City of L.A.				0.025000	0.025000	312,687	3,828	10,230	11,047	13,264	13,389	11,175	11,397	12,770
Madera	88,090	0.002860	0.002664	0.002664	0.002664	32,309	408	1,090	1,177	1,413	1,427	1,191	1,214	1,361
Marin	230,096	0.007732	0.006969	0.006969	0.006969	87,006	1,066	2,847	3,075	3,692	3,727	3,110	3,172	3,555
Mariposa	14,302	0.000481	0.000433	0.000433	0.000433	6,408	65	177	191	229	232	183	187	221
Mendocino	80,345	0.002700	0.002430	0.002430	0.002430	30,281	372	894	1,074	1,289	1,301	1,088	1,108	1,241
Merced	178,403	0.005895	0.005385	0.005385	0.005385	67,459	826	2,208	2,384	2,862	2,880	2,412	2,458	2,756
Modoc	9,678	0.000325	0.000293	0.000293	0.000293	3,650	45	120	129	155	157	131	133	150
Mono	9,956	0.000335	0.000301	0.000301	0.000301	3,785	46	123	133	160	161	135	137	154
Monterey	355,660	0.011851	0.010756	0.010756	0.010756	134,485	1,647	4,401	4,753	5,707	5,761	4,808	4,903	5,484
Napa	110,785	0.003722	0.003350	0.003350	0.003350	41,883	513	1,371	1,480	1,784	1,794	1,487	1,527	1,711
Nevada	78,510	0.002638	0.002374	0.002374	0.002374	29,887	364	872	1,049	1,260	1,272	1,061	1,082	1,213
Orange	2,410,556	0.081000	0.072800	0.072800	0.072800	911,802	11,166	28,830	32,212	38,677	39,043	32,586	33,232	37,238
Placer	172,796	0.005808	0.005226	0.005226	0.005226	66,338	800	2,136	2,309	2,772	2,799	2,336	2,382	2,669
Plumas	18,738	0.000663	0.000597	0.000597	0.000597	7,484	91	244	284	317	320	267	272	305
Riverside	1,170,413	0.039328	0.035396	0.035396	0.035396	442,668	5,421	14,484	15,640	18,779	18,957	15,822	16,136	18,080
Sacramento	1,041,219	0.034987	0.031488	0.031488	0.031488	389,715	4,823	12,885	13,914	16,708	16,864	14,075	14,354	16,085
San Benito	36,697	0.001233	0.001110	0.001110	0.001110	13,876	170	454	490	589	594	496	506	567
San Bernardino	1,418,380	0.047861	0.042895	0.042895	0.042895	638,331	6,570	17,562	18,954	22,758	22,973	19,174	19,654	21,811
San Diego Only	2,498,016	0.083939	0.075545	0.075545	0.075545	944,573	11,571	30,913	33,381	40,060	40,460	33,768	34,438	38,589
City of S.D.				0.025000	0.025000	312,687	3,829	10,230	11,047	13,264	13,389	11,175	11,397	12,770
San Francisco C&C	723,959	0.024327	0.021894	0.021894	0.021894	586,237	7,183	19,189	20,721	24,880	25,115	20,961	21,377	23,954
San Joaquin	480,628	0.016150	0.014535	0.014535	0.014535	181,740	2,226	5,948	6,423	7,712	7,785	6,497	6,626	7,425
San Luis Obispo	217,162	0.007297	0.006567	0.006567	0.006567	82,115	1,006	2,687	2,902	3,484	3,517	2,936	2,994	3,365
San Mateo	649,623	0.021829	0.019846	0.019846	0.019846	245,642	3,009	8,039	8,681	10,423	10,522	8,782	8,958	10,005
Santa Barbara	369,608	0.012420	0.011178	0.011178	0.011178	189,760	1,712	4,574	4,808	5,930	5,986	4,896	5,095	5,710
Santa Clara	1,497,577	0.050322	0.045290	0.045290	0.045290	656,278	6,937	18,532	20,012	24,028	24,256	20,244	20,648	23,135
City of San Jose				0.025000	0.025000	312,687	3,829	10,230	11,047	13,264	13,389	11,175	11,397	12,770
Santa Cruz	229,734	0.007720	0.006948	0.006948	0.006948	89,859	1,084	2,843	3,070	3,686	3,721	3,106	3,167	3,549
Shasta	147,036	0.004941	0.004447	0.004447	0.004447	58,639	681	1,820	1,985	2,359	2,382	1,988	2,027	2,271
Sierra	3,318	0.000111	0.000100	0.000100	0.000100	1,255	15	41	44	53	54	45	46	51
Siskiyou	43,531	0.001483	0.001316	0.001316	0.001316	16,460	202	539	582	688	705	588	600	672
Solano	340,421	0.011439	0.010295	0.010295	0.010295	128,722	1,577	4,213	4,549	5,462	5,514	4,602	4,683	5,259
Sonoma	388,222	0.013045	0.011741	0.011741	0.011741	148,798	1,798	4,804	5,188	6,228	6,288	5,248	5,352	5,997



California Local Government Allocation of Potential Recovery  
(in 000's)

COUNTY	1990 Census Pop	% Pop	Only Share	City Share	Total Share	Total Payout All Years	1998	2000	2001	2002	2003	2004-2007 per year	2008-2017 per year	2018-2025 per year
Stanislaus	370,522	0.012450	0.011205		0.011205	140,105	1,716	4,585	4,951	5,945	6,001	5,009	5,108	5,724
Sutter	64,415	0.002164	0.001848		0.001848	24,367	288	797	861	1,004	1,043	871	868	895
Tehama	49,625	0.001688	0.001501		0.001501	18,785	230	614	663	798	804	671	684	787
Tulare	13,063	0.000439	0.000395		0.000395	4,940	61	162	176	210	212	177	180	202
Tuolumne	311,921	0.010481	0.009433		0.009433	117,846	1,445	3,860	4,168	5,005	5,062	4,217	4,300	4,819
Ventura	48,456	0.001628	0.001465		0.001465	18,322	224	600	648	777	765	655	668	749
Yuba	689,016	0.022480	0.020232		0.020232	262,975	3,099	8,279	8,940	10,734	10,836	9,044	9,223	10,335
Totals	141,092	0.004741	0.004267		0.004267	53,361	654	1,748	1,885	2,264	2,265	1,907	1,945	2,180
	58,228	0.001857	0.001761		0.001761	22,018	270	721	778	934	943	787	803	900
Totals	29,760,021	1.000	0.900	0.100	1.000	12,503,488	163,167	409,196	441,866	530,652	536,573	446,993	456,864	610,813









# **SAN FRANCISCO NURSING FACILITY BED STUDY**

## **Main Report**

**The San Francisco Section  
of the West Bay Hospital Conference**

Hospital Council of Northern and Central California

**May 1997**

### **Project Consultant:**

The San Francisco Nursing Facility Bed Study was researched and written by Bill Haskell, a San Francisco-based consultant specializing in health care planning and program development services. A complete review of Mr. Haskell's experience is found in the Afterword, on page 69 of this report.

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This effort is one of many underway in San Francisco to address the needs of the community, rather than the needs of specific institutions. The working partnerships between the public and private sectors reflect a primary consideration - the desire to enhance the health status and well being of San Francisco residents.

Special acknowledgment is made to: Anthony G. Wagner, Executive Administrator of Laguna Honda Hospital and Rehabilitation Center, who introduced this project to his colleagues; Martin H. Diamond, Director, UCSF/Mount Zion Medical Center and Chair of the San Francisco Section of the West Bay Hospital Conference; and Nathan Nayman, Regional Vice President, Hospital Council of Northern and Central California.

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Saint Francis Memorial Hospital, and  
St. Mary's Hospital and Medical Center  
St. Luke's Hospital  
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# Statement of Purpose

San Francisco has a large and growing elderly population, many of whom will require long term care. While the numbers of elderly persons 65 and over is constantly increasing, the substantial growth in the elderly population will occur from 2010 to 2020. Hopefully, the relatively low rate of growth in this population over the next several years will provide an opportunity to plan for the rapid growth which will begin to occur after 2010. Increasing numbers of disabled and chronically ill persons will also require long term care.

This Nursing Facility Bed Study was initiated to investigate the relationship between the future supply and demand for nursing facility (NF) beds. Its purpose is to: (1) analyze the potential supply of NF beds for long term care; (2) evaluate the potential demand for NF beds for long term care by considering the needs of the whole population; and (3) review the overall seismic capability of San Francisco's acute hospital buildings to accommodate NF beds. The Study's findings are intended to assist in strategic planning regarding the need for long term care services, and the future availability of NF beds in San Francisco.

Laguna Honda Hospital, owned by the City and County of San Francisco and operated as a division of the Department of Public Health (DPH), is the largest municipally owned single-site long term care facility in the nation. However, the principal buildings are now old and have serious physical deficiencies. To face the challenge of providing long term health care services to the City's increasing elderly and disabled population, DPH initially developed a proposal to replace existing structures with a new, modern 1,207 bed facility.

In FY 1994-95, this proposal was reevaluated because: (1) the new, large long term care facility would be expensive, at a 1994-95 cost of \$482 million; (2) significant changes in health care services delivery precluded such a substantial financial commitment; and (3) the increasing emphasis on home and community-based long term care options needed to be evaluated. In addition, (4) the future utilization of acute beds in San Francisco's hospitals needed to be fully explored.

While some financial information is provided, this Study is considered a capacity analysis - not a financial analysis. A financial analysis would assist in determining the financial feasibility for hospitals to convert acute beds to NF beds. Such an analysis may be the next step in evaluating the potential of converting acute beds to NF beds, in order to address a portion of the demand for long term care.

Each hospital is continuously involved in its own strategic planning process, attempting to improve efficiency and strengthen its place in the San Francisco health care market. The information provided within the individual hospital profiles, found in the Appendices, reflects the position of each hospital at the time of the interview. It is entirely possible that some of this information may not reflect the plans of a particular hospital after June of 1996.



## **Section 1.**

### **The Potential Supply of Nursing Facility (NF) Beds to Address the Demand for Long Term Care**

## **Section 1. The Potential Supply of Nursing Facility (NF) Beds to Address the Demand for Long Term Care**

San Francisco has an existing supply of nursing facility (NF) beds in long term care facilities, hospital-based nursing facilities, and freestanding nursing facilities to address the demand for long term care. In addition, there may be available capacity in hospitals to address long term care needs. This section presents: (1) a review of the existing supply of NF beds, (2) an analysis of the available acute bed capacity for long term care, and (3) an estimate of total surplus acute beds available for conversion to NF beds, as of June 1996.

NOTE: Seton Medical Center is included due to its geographic proximity. However, Seton serves residents of San Mateo County as well as San Francisco County. San Mateo County is also evaluating strategies for long term care that could impact services provided by Seton. As such, total NF and acute bed availability and surplus bed capacity attributed to Seton in serving the needs of San Francisco residents are overstated. The reader should be aware of this fact in any reference to Seton Medical Center throughout this study.

### **1. Total Available NF Bed Capacity in Long Term Care Facilities**

Two of San Francisco's 14 hospitals primarily provide long term care services. These include: (1) Laguna Honda Hospital, licensed as a general acute care hospital with a distinct part nursing facility, with 1,214 NF beds; and (2) the Jewish Home for the Aged, licensed as an acute psychiatric hospital with a distinct part nursing facility, with 437 NF beds.

### **2. Total Available NF Bed Capacity in Acute Care Hospitals**

Twelve of San Francisco's 14 hospitals primarily provide acute care services. Of these, 8 hospitals operate distinct part nursing facilities with a total of 450 hospital-based NF beds that currently provide both post-acute and long term care services.

**NF Beds Available in Hospitals**

<b>Hospital Name</b>	<b>Staffed Beds in Hospital-Based Nursing Facilities</b>
Chinese Hospital	0
California Pacific Medical Center	97
Kaiser Medical Center	0
Davies Medical Center	51
San Francisco General Hospital	19
Saint Francis Memorial Hospital	34
St. Luke's Hospital	79
St. Mary's Medical Center	48
UCSF Medical Center/Mount Zion	31
VA Medical Center	0
Pacific Coast Hospital	0
Seton Medical Center	91
<b>TOTAL</b>	<b>450 NF Beds</b>

### **3. Total Available NF Bed Capacity in VA Medical Center**

The VA Medical Center does not maintain hospital-based NF beds. However, it does operate a separate 120 bed nursing home that provides long term care.

### **4. Total Available NF Bed Capacity in Freestanding Nursing Facilities**

San Francisco also has 19 freestanding nursing facilities that currently provide a total of 1,404 NF beds for long term care. Based on a telephone survey conducted in July 1996, all of these nursing facilities intend to remain in the San Francisco market.

#### **NF Beds Available in Freestanding Nursing Facilities**

<b>Freestanding Nursing Facility Name</b>	<b>Staffed Beds in Freestanding Nursing Facilities</b>
Beverly Manor	168
California Convalescent Hospital	27
Central Gardens Convalescent Hospital	92
The Heritage	32
Convalescent Center - Mission Street	53
Mission Villa Convalescent Hospital	48
Sequoias Convalescent Hospital*	49
St. Anne's Home	48
Mission Bay Convalescent Hospital	48
Sheffield Convalescent Hospital	34
Hayes Convalescent Hospital	32
San Francisco Community Convalescent Hospital	116
Laurel Heights Convalescent Hospital	32
Parc Pacific Convalescent Hospital	48
Vencor - Victorian Health Center	90
Vencor - 19th Avenue Health Center	140
Vencor - Nobb Hill Health Center	172
Vencor - Laughton Health Care Center	65
Vencor - Golden Gate Health Care Center	110
<b>TOTAL</b>	<b>1,404 NF Beds</b>

NOTE: Sequoias Convalescent Hospital is part of Sequoias Life Care Facility. It does not take patients from the community who reside outside its life care environment.

### **5. Summary of Existing Supply of Nursing Facility (NF) Beds**

San Francisco currently has a total of 3,625 nursing facility (NF) beds. This includes:

<b>Laguna Honda Hospital</b>	<b>1,214</b>
<b>The Jewish Home for the Aged</b>	<b>437</b>
<b>Hospital-Based Nursing Facilities</b>	<b>450</b>
<b>VA Nursing Home</b>	<b>120</b>
<b>Freestanding Nursing Facilities</b>	<b><u>1,404</u></b>
	<b>3,625 NF Beds</b>



## 6. Total Available Acute Bed Capacity in Hospitals to Address the Demand for Long Term Care

Several of San Francisco's 12 acute care hospitals consistently report low occupancy. A perception exists that a number of hospital beds could be converted to address the demand for post-acute and long term care. Interviews conducted reveal that the actual potential is less than the perceived potential.

Licensed beds. There are a total of 5,211 licensed acute beds in San Francisco. However, hospitals and health care providers have been experiencing a shift in service delivery away from inpatient to outpatient services for the past several years. Due to this shift, competing needs for licensed bed space have arisen to accommodate different activities not directly related to inpatient care. Consequently, this study does include references to licensed acute beds because they do not accurately reflect available acute bed capacity.

Available beds. Available beds are those a hospital could, if necessary, activate for inpatient service delivery. Total available bed capacity in hospitals is 3,687 beds, including 450 NF beds. Reducing the total available bed capacity by the 450 NF beds provides the remaining balance of 3,237 beds, which represents the total available acute bed capacity. Total acute average daily census in San Francisco hospitals as of June 1996 was 1,783 beds, resulting in a difference of 1,454 acute beds. However, seasonal fluctuations in bed need and emergency preparedness reduce the total potential acute beds available for conversion to NF beds to 1,090 beds. The following table presents bed capacities in hospitals as of June 1996.

**Bed Capacities in Hospitals, June 1996**

Hospital Name	Total Available Beds	Total Available Acute Beds	Acute Average Daily Census	Difference
Chinese Hospital	59	59	36	23
California Pacific Medical Center	434	337	228	109
Kaiser Medical Center	226	226	151	75
Davies Medical Center	323	272	44	228
San Francisco General Hospital	357	338	270	68
Saint Francis Memorial Hospital	225	191	82	109
St. Luke's Hospital	180	101	70	31
St. Mary's Medical Center	496	448	173	275
UCSF Medical Center/Mount Zion	815	784	441	343
VA Medical Center	244	244	155	89
Pacific Coast Hospital	28	28	1	27
Seton Medical Center	300	209	132	77
<b>SUBTOTALS</b>	<b>3,687</b>	<b>3,237</b>	<b>1,783</b>	<b>1,454</b>
Seasonal fluctuations in bed need and emergency preparedness				- 364
<b>TOTAL</b>				<b>1,090</b>



## 7. Total Acute Beds Available for Conversion to NF Beds, Estimated by Hospitals as of June 1996

The findings concerning bed capacity do not conform with the bed availability numbers estimated by San Francisco hospitals. Based on hospital interviews which took place in May and June, hospitals estimated a total surplus of 314 acute beds existed as of June 1996. Of that surplus, hospitals estimated a total potential of 271 acute beds were available for conversion to NF beds to address the demand for long term care in the immediate future.

### Results of Hospital Interviews, June 1996

Hospital Name	Total Estimated Surplus of Acute Beds	Total Estimated Acute Beds Available for Conversion to NF Beds
Chinese Hospital	None	None
California Pacific Medical Center	None	None
Kaiser Medical Center	None	None
Davies Medical Center	80 beds	80 beds
San Francisco General Hospital	None	None
Saint Francis Memorial Hospital	50 beds	44 beds
St. Luke's Hospital	40 beds	40 beds
St. Mary's Medical Center	90 beds	32 beds
UCSF Medical Center/Mount Zion	None*	21 beds*
VA Medical Center	None	None
Pacific Coast Hospital	18 beds	18 beds
Seton Medical Center	36 beds	36 beds
<b>TOTALS</b>	<b>314 beds</b>	<b>271 beds</b>

\* NOTE: The UCSF Medical Center /Mount Zion projected no surplus in acute beds as of June 1996. However, an existing 31 bed nursing facility unit at Mount Zion could be expanded by approximately 21 beds.

Hospitals explain they have little acute care bed space available for conversion to NF beds in the immediate future for a variety of reasons. These include:

- census numbers reflect midnight activity only.
- the expansion or consolidation of health care programs.
- mergers.
- research space.
- unfinished strategic planning processes.
- participation in regional delivery systems.
- a need to retain surplus acute care beds in San Francisco.
- beds are governed by organizations that solely determine their availability.

Hospital Profiles. Individual hospital profiles can be found in Appendix A. Each profile provides: (1) a hospital description based on reported information; (2) observations based on an interview; (3) a brief description of the nursing facility level of care provided; and (4) the potential for additional NF beds at the institution. Each hospital is continuously involved in its own strategic planning process. The information provided in each profile reflects the position of the hospital at the time of the interview. It is entirely possible that some of this information may not reflect the plans of a particular hospital after June 1996.

## **8. Subacute Care Beds and Transitional Inpatient Care Beds in Hospitals and Freestanding Nursing Facilities**

There are three subacute care units in San Francisco. Two of these are in hospitals and one is in a freestanding nursing facility. These subacute care units have been established under California's Adult Subacute Care Program, and provide a total of 105 subacute beds. All subacute beds in these units have been included in the NF bed totals already presented for hospital-based and freestanding nursing facilities.

There are six hospitals and nursing facilities in San Francisco certified to receive reimbursement for transitional inpatient care. The transitional inpatient care in these hospitals and nursing facilities has been established under California's Transitional Inpatient Care (TIC) Program, and provides a total of 58 TIC beds. Within each institution, these TIC beds are integrated into nursing facility units, or acute medical and surgical units, and used on an as-needed basis.

The specific impact of these subacute care beds and TIC beds on ability of hospital-based and freestanding nursing facilities to address the demand for long term care is not clear at the present time. Subacute care and transitional inpatient care are discussed in greater detail in Section 2. Trends in Long Term Care Service Delivery, under post-acute service delivery starting on page 29.

Freestanding Nursing Facility Survey. The results of the freestanding nursing facility survey can be found in Appendix B. The Survey presents: (1) licensed beds; (2) operating beds; (3) average daily census; (4) percent of occupancy; and (5) total available beds.

## **9. Potential Impact of California's New Seismic Safety Standards on the Conversion of Acute Beds to NF Beds**

California's new seismic safety standards may impact the availability of acute beds in San Francisco hospitals that could be converted to NF beds, and the current hospital-based NF bed capacity, to address the demand for long term care. As individual hospitals weigh the costs and benefits of retrofitting existing acute care facilities, downsizing and retrofitting existing facilities, or building new scaled-down facilities to meet the current market needs, the supply of acute and NF beds may be reduced.

Hospitals have until July 1, 2000 to conduct evaluations of their acute care facilities based on the new seismic standards that will be issued. Without knowing in advance what each hospital will decide following such evaluations, this study makes the assumption that some San Francisco hospitals will undertake necessary seismic retrofits to continue to provide acute care. The study further assumes that the potential will exist to convert all or part of some hospital buildings to nursing facility services, and that the existing supply of hospital-based NF beds will be maintained. Section 6. Seismic Safety Standards for California Hospitals explores the new seismic safety standards.

## **Section 2.**

### **Trends in Long Term Care Service Delivery**



## **Section 2. Trends in Long Term Care Service Delivery**

This section provides an overview of national, state and local trends in long term care service delivery. It also provides a summary of trends in post-acute care service delivery.

### **1. Background**

Long term care is currently defined as a set of health care, personal care, and social services delivered over a sustained period of time to persons whose capacity to live independently is compromised by physical, mental, or cognitive limitations. This care can be provided either in institutional settings or in home and community-based settings. A comprehensive definition of long term care services is found in Appendix H.

The need for long term care is generally defined by limitations in the ability of individuals to independently perform basic self care and household tasks. About 12.7 million persons in the U.S. are estimated to need long term care assistance. These persons require help with either: (1) the activities of daily living (ADLs) such as eating, dressing, bathing, getting in or out of bed, or using the toilet; or (2) the instrumental activities of daily living (IADLs) such as housekeeping, buying groceries, or managing money. Long term care is provided in institutional settings as well as in home and community-based settings.

<b><u>Activities of Daily Living</u></b> <b>(ADLs)</b>	<b>Generally include eating, bathing, dressing, getting to and using the bathroom, getting in or out of a bed or chair, and mobility.</b>
<b><u>Instrumental Activities of Daily Living</u></b> <b>(IADLs)</b>	<b>Generally include going outside the home, keeping track of money or bills, preparing meals, doing light housework, using the telephone, and taking medicine.</b>

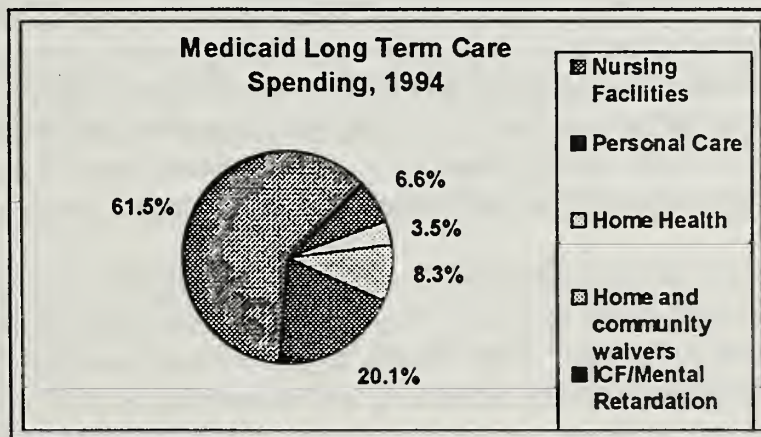
The primary recipients of long term care are older people because of the higher prevalence of chronic illness in this population. Other recipients include people with developmental disabilities or mental illness, and people with chronic infectious diseases like tuberculosis and AIDS. Chronic illness may lead to disability or functional impairment, increasing the need for institutionalization. While most people (58%) needing long term care are elderly, 2% are children and 40% are working age adults.<sup>1</sup>



Approximately 5% of elderly persons live in nursing facilities in the United States. Of the population 65 and older, it is expected that 52% of the women and 33% of the men will use a nursing facility at some point in their lives. Of the frail elderly population (85 and older) between 10% and 20% are now living in nursing facilities. Based on the current configuration of long term care services, it is estimated that approximately 20% of persons 65 and older will require institutional care for a specific period. However, these percentages may shift as the nature of health care delivery changes across the country.<sup>2</sup>

Of the 12.7 million people needing long term care assistance, 2.4 million of these live in institutions such as nursing facilities or intermediate care facilities for the mentally retarded, while 10.3 million live at home or in small community residential settings such as group homes or supervised apartments. There are 6.2 million people who need help with basic self care tasks, 2.4 million of whom live in institutions - most of these individuals are over 65 years old. Of the 5.1 million who are most severely disabled, 1.3 million live in the community and need assistance with three or more self-care tasks.<sup>3</sup>

Medicaid is the principle government program supporting long term care services. About three-quarters of all Medicaid spending for the elderly is for long term care, especially for nursing facility care. Currently, limited public funds pay for home and community-based services. In 1994, Medicaid spent \$45.7 billion for long term care, a little more than a third of the total Medicaid expenditures that year.<sup>4</sup>



**Total: \$45.7 Billion**

Source: HCFA

## **National Trends**

The projected increase in the growth of the older population, with a higher risk of chronic illness, has generated considerable national interest in exploring alternate methods for financing and delivering cost-effective long term care services.

Efforts are being made to increase reliance on home and community-based services, and reduce the emphasis on institutional care. Other cost control strategies include limits on nursing facility beds, "capping" budgets, controls on provider fees, and long term care case management. States are taking the lead in this shift, hoping to contain costs while responding to the desire of elderly and disabled people to avoid institutionalization.

### • Emerging Models Of Long Term Care Service Delivery

Several states are reconfiguring long term care service delivery to emphasize: (1) greater reliance on home and community-based services; (2) consolidation of administrative responsibility for long term care services; (3) the development of additional residential options, including supportive housing, as part of the continuum of long term care services; and (4) stronger limits on the supply of institutional care beds. See Appendix H (A Definition of Long Term Care), for a definition of home and community-based services.

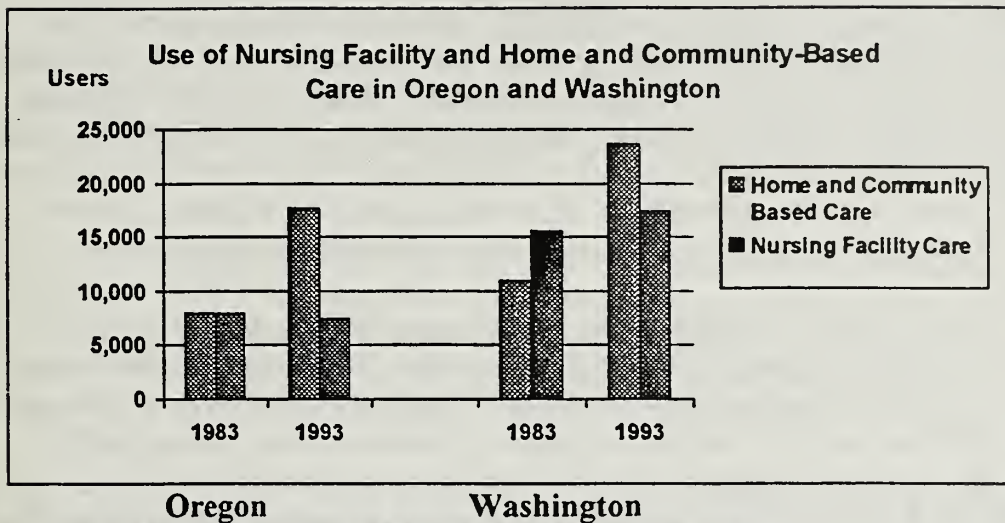
Emerging models of service delivery reflect a desire of many elderly and disabled people to be as independent as possible in their homes and communities. These models incorporate individualized planning to address a person's specific needs, preferences, and the availability of community supports, including informal, unpaid caregiving.

**Oregon, Washington and Wisconsin** are three states that have developed innovative models for the delivery of long term care services for elderly and disabled persons. Each has a long-standing Medicaid Waiver program to fund home and community-based care for persons who meet Medicaid eligibility requirements and would otherwise require institutional care. While each state has used various strategies to control program growth, all three have placed additional restrictions beyond federal limits on program size, prompted in part by state budget limitations. These restrictions involve: (1) financial eligibility criteria; (2) functional eligibility criteria; (3) and a variety of program management techniques such as controls on provider fees, capped service budgets, case management, and limits on new nursing home beds. Also, **Arizona** is the first state with a capitated managed care system combining Medicaid acute and long term care services.

Some of these states also set up a consolidated administrative authority over both institutional and community-based services to help move individuals from institutional care to home and community-based care. State officials singled out case management as especially useful in controlling costs by authorizing and monitoring services, and by ensuring beneficiaries receive the support services they need to stay out of institutions.

As a result of the shift from institutional care to home and community-based care, Oregon, Washington, and Wisconsin have been able to provide long term care to more people with available funds. In addition, these states have been able to accommodate all or most of the growth in their long term care programs in home and community-based care. Some state officials believe their ability to provide home and community-based care through state-funded and Medicaid Waiver programs has allowed their states to successfully contain growth in overall state long term care spending. **In these states, the combined number of new nursing facility beds declined by 1.3% between 1982 and 1992, while the number of nursing facility beds in the U.S. in the same period increased by 20.5%.**





NOTE: Wisconsin is not included because comparable data were not available.

While some states have taken a more aggressive approach to increasing the provision of home and community-based long term care services, each state maintains a mixture of both nursing facility services and home and community-based long term care services. The following table shows the percentage of users in each of the states investigated.

#### **Nursing Facility Services and Home & Community-Based Services in States with Innovative Long Term Care Service Delivery Models**

	Home and Community-Based Services	Nursing Facility Services
Oregon	54.7%	45.3%
Washington	55.8%	44.2%
Wisconsin	31.5%	68.5%
Arizona	35.0%	65.0%

### **Oregon's Long Term Care Delivery System**

Oregon operates under a policy that increases availability of home and community-based services, and decreases availability of freestanding nursing facilities. Oregon has actively developed non-institutional alternative living arrangements for elderly and disabled persons who require long term care.

Oregon's structure for administering long term care services. In 1981, the Senior and Disabled Services Division in the Department of Human Resources was established to administer all long term care functions. This agency is responsible for: (1) licensing and certification of freestanding nursing facilities; (2) federal programs for seniors financed by Medicaid and the Older Americans Act; and (3) state programs for the elderly and for younger adults with disabilities.<sup>5</sup>

Oregon's model of long term care service delivery. Oregon's model of long term care service delivery includes: (1) a policy promoting independence and choice for elderly and disabled persons; (2) easy access to services at the local level; (3) extensive use of home and community-based services; (4) case managers authorizing services; (5) a strong focus on relocating elderly and disabled persons from nursing facilities; (6) a certificate of need (CON) requirement for nursing homes; and (7) a range of supportive housing options including congregate housing, adult foster care homes, and assisted living facilities.

In the early 1980s, Oregon set a target range for the use of NF beds at between 35 to 45 NF beds per 1,000 persons age 65 and over (this addressed the needs of the elderly and the disabled). In 1981, Oregon received approval of the first Medicaid waiver for home and community-based services for Medicaid eligible persons who need nursing facility care. The state promoted the growth of adult foster care homes and assisted living facilities. About 8,400 Medicaid beneficiaries in Oregon lived in nursing facilities in 1981.

Between 1981 and 1996, Medicaid beneficiaries in nursing facilities dropped to 7,400 persons. During the same 15 year period, the number of persons needing long term care services in the community grew from about 3,000 to 18,000. By 1992, the NF bed ratio was down to 36 NF beds per 1,000 persons age 65 and over, one of the lowest ratios in the country at that time. All of the growth in the 85 and over population needing long term care has been absorbed into home and community-based care. Approximately 16% of all participants in home and community-based care programs are disabled.

### **Oregon's Long Term Care Beds, Provided in Alternative Residential Settings and in Nursing Facilities, as of May 1996**

	Medicaid Beds	Percentage
<b>Residential Care Facilities</b>	960	6.0%
<b>Assisted Living Facilities</b>	1,020	6.4%
<b>Adult Foster Care Homes</b>	5,400	34.1%
<b>Relative Adult Foster Care Homes*</b>	1,300	8.2%
<b>Nursing Facilities</b>	7,180	45.3%
<b>TOTAL</b>	<b>15,860**</b>	<b>100.0%</b>

\* These are foster care homes operated by relatives, and do not have to be licensed by the State of Oregon.

\*\* As of 1996, Oregon had 18,000 community-based long term care slots. Except for nursing facilities, all of the above are residential settings, excluding private homes, where long term care is provided. Home care is not included.

Oregon's NF bed ratio in 1996 was 27 NF beds per 1,000 persons age 65 and over, which once again is the lowest ratio in the country. This ratio incorporates the need for all hospital-based and freestanding NF beds. Even with a low NF bed ratio, 45.3% of the population eligible for long term care resides in nursing facilities. The balance, or 54.7% of the eligible population, is in alternative residential settings.



Persons in nursing facilities in Oregon receiving long term care are those who: (1) have a greater need for skilled care and require more nursing interventions, or (2) do not interact extensively with their environment, or (3) cannot benefit from home and community-based care. Over 50% of people in nursing facilities are dependent in all ADLs, demented, or terminally ill. As a result, many nursing facilities are providing what is considered to be subacute care.

Oregon's long term care service delivery system is based on the state model which assures that elderly and disabled persons who need long term care can access services. The service delivery system emphasizes values of choice, independence, and dignity of the individual. The system includes components that address access, assessment, service planning and implementation, monitoring, and closure when services are no longer needed.

The chart on the next page illustrates Oregon's long term care service delivery system. It shows the importance of public information, information and assistance, and protective services which should be available to all elderly and disabled adults - in contrast to fragmented systems designed to discourage all but the most needy persons from accessing the programs. The service delivery system emphasizes the concept of single entry.

All persons who need long term care are entitled to an assessment to help identify service needs and how those needs can be met. The assessment results may vary from simple information and assistance to full long term care services. Pre-admission assessment is available without regard to income. This system emphasizes coordination, and assists individuals in developing and implementing a flexible individualized service plan that can be monitored and revised if conditions, resources, or needs change.

By 1993, 68% of the aged and persons with physical disabilities who were beneficiaries of publicly funded long term care in Oregon were receiving their care in their homes and in other community settings, compared with 49% in 1983.

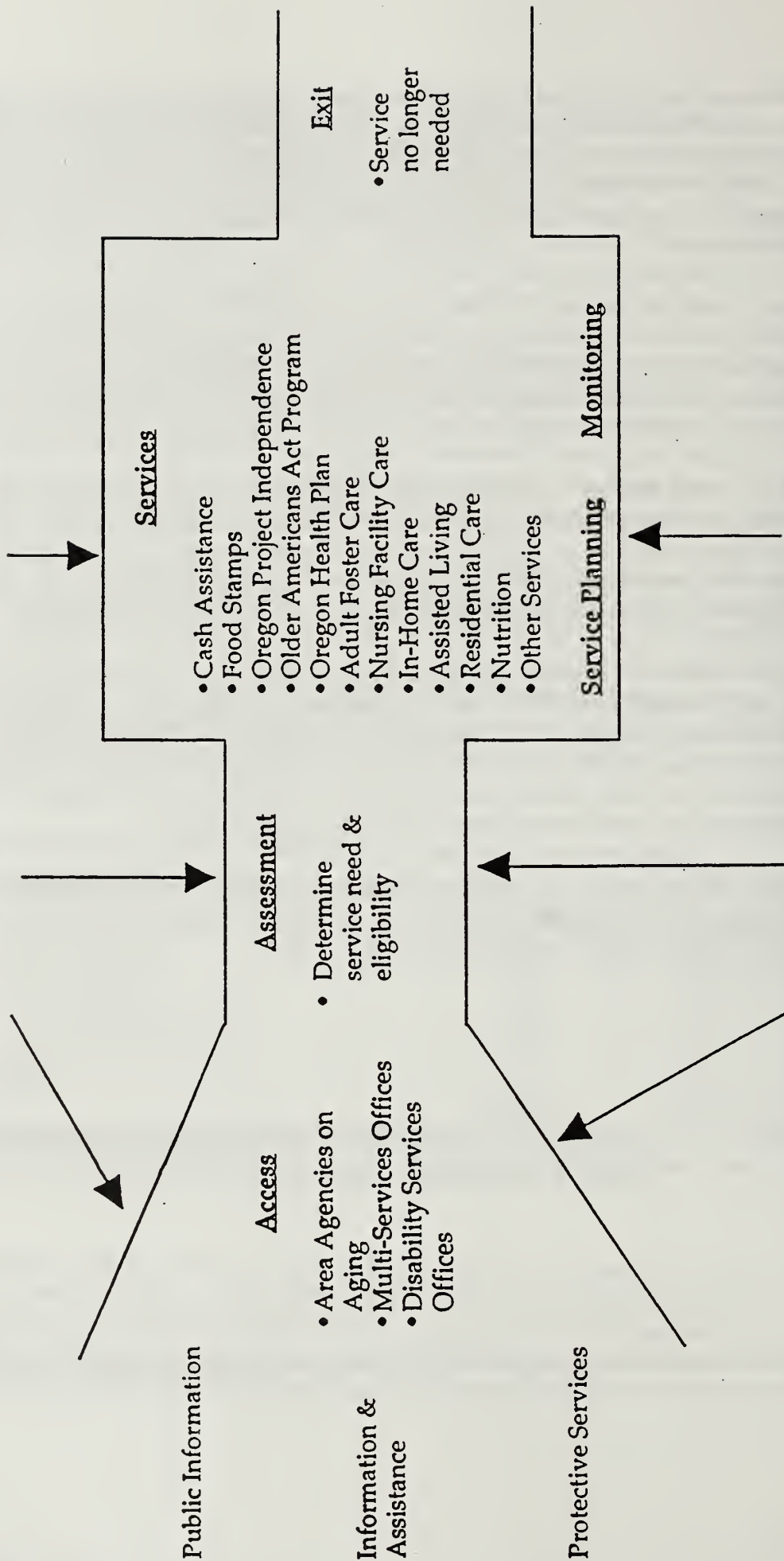
## **SEE THE OREGON LONG TERM CARE SERVICE DELIVERY SYSTEM ON THE FOLLOWING PAGE**

The role of the county in Oregon's long term care service delivery system is presented in Appendix I.

# SDSD Budget Overview

## The Service Delivery System

### Disability Services Advisory Councils



### Senior Services Advisory Councils

## Washington's Long Term Care Delivery System

Washington adopted a policy in the 1980s to deliver long term care through home and community-based settings whenever possible, in response to a dramatic rise in spending on institutional long term care services. Medicaid spending on nursing home care in Washington State rose from \$290 million in the 1981-1983 biennium to \$922 (218%) in 1993-1995. During this period, the nursing home caseload rose about 12%.

Washington's structure for administering long term care services. To address this issue, Washington established a single state agency responsible for institutional and non-institutional long term care services for aged and physically disabled persons: this is the Aging and Adult Services Administration in the Department of Health Services. Washington developed four home and community-based care programs, including a Medicaid waiver program, a nonwaiver Medicaid personal care program, and two state-funded programs for persons who do not qualify for Medicaid. **In 1993, 55.8% of the 39,500 beneficiaries receiving Medicaid or state-supported long term care during an average month were being cared for in home and community-based settings. The remainder, or 44.2% of the beneficiaries were being cared for in nursing facilities.**

Washington's model of long term care service delivery. Washington's four home and community-based care programs for aged and disabled persons served an average of about 22,000 persons per month in 1993, compared with about 17,400 persons in the nursing facilities program. All four home and community-based programs provide personal care services to assist beneficiaries with activities of daily living (ADLs). However, each program differs in its funding source and the amount of services it provides. Because of different requirements, some individuals may qualify for more than one program, but they receive services only through one. The state's objective is to provide the most suitable services through the lowest cost. Placement in a program is based on such factors as the individual's need for services and the availability of support from family and friends.

Specifically, Washington took the following actions to slow nursing home growth:

- In 1983, the state established a Medicaid waiver program called Community Options Program Entry System (COPES) to provide additional community care options for elderly and disabled people who require long term care. COPES serves low income persons who do not receive cash payments and have income and resources below specified limits.
- The nonwaiver Medicaid program is limited to persons who receive federally assisted income maintenance payments or would be eligible to receive payments if they applied.
- The Chore Services program, the larger of the two state-funded programs, serves persons at risk for institutionalization but not eligible for Medicaid.



- The Adult Residential Care program is a small program that covers individuals in adult family homes and congregate care facilities who are not eligible for Medicaid.
- In 1989, the state incorporated into its Certificate of Need (CON) statute a goal to reduce nursing home beds from 54 to 45 per 1,000 persons age 65 and over. By 1992, the ratio had dropped to 49 per 1,000 elderly residents.

As a result of these actions, in 1996 Washington's NF bed ratio in 1996 was 45 NF beds per 1,000 persons age 65 and over.

In 1993, 85% of the aged and disabled persons in the four home and community-based care programs received services in their own homes. The remaining 15% received care in alternative living arrangements such as adult family homes or assisted living facilities. The state encourages private sector development of these living arrangements.

### Washington's Long Term Care Service Program for Aged and Physically Disabled Persons

	Services Provided	Average Monthly Users	Av. Monthly Expenditure per user	Funding Sources
<b>Institutional care:</b>				
• Nursing Facilities	Personal care and services provided by licensed nursing personnel	17,428 (44.2%)	\$2,023	Medicaid
<b>Home &amp; community based care:</b>				
• COPES program	Personal care, related household tasks, case management, supervision	4,840	\$815	Medicaid (Waiver)
• Medicaid Personal Care	Personal care, household tasks	7,823	\$358	Medicaid (Nonwaiver)
• Chore Services	Personal care, household tasks	8,656	\$265	State
• Adult Residential Care	Personal care, and supervision	721	\$259	State
<b>All home &amp; community-based programs</b>		<b>22,040 (55.8%)</b>		



Over the past decade, Washington's officials believe increasing reliance on home and community-based care for the aged and persons with physical disabilities has helped control the rate of growth in overall long term care expenditures while allowing the state to serve more beneficiaries. By expanding home and community-based care, which is less expensive per person than institutional care, and by controlling growth in the capacity and use of nursing facilities, Washington has been able to serve more people with the available dollars than could have been served under a program that relied more heavily on institutional care. Both the federal Medicaid program and state controls on the growth of home and community-based services have limited access to services at times.

## **Wisconsin's Long Term Care Delivery System**

Although it began in the 1980s with one of the nation's highest ratios of nursing facility beds to elderly population, Wisconsin has been able to constrain Medicaid nursing facility utilization and moderate growth in expenditures, while serving more long term care beneficiaries with home and community-based care. Wisconsin provides home and community-based long term care services for aged and physical disabled persons with through Medicaid home health and personal care services, a Medicaid waiver program, and the state-funded Community Options Program (COP).

Wisconsin's structure for administering long term care services. While responsibility for long term care is consolidated in the Department of Health and Social Services, the management of individual programs is divided among different divisions. The Medicaid waiver and state-funded COP are managed by one division, while the regular Medicaid program and the state's nursing homes are managed by another division.

Wisconsin's model of long term care service delivery. Specifically, Wisconsin's long term care system includes both institutional care in the state's nursing homes, and home and community-based care which is built around the Medicaid waiver program:

- When building a package of services, case managers are required to provide services through the regular Medicaid program and the Medicaid waivers, if the needed services are available.
- If a beneficiary requires services that are not available through the Medicaid waivers, then case managers can rely on services from the state-funded Community Options Program (COP).
- Although eligibility for Medicaid waiver services is restricted to those financially eligible for Medicaid, waiver recipients must also have received services in an institutional setting, or have been at risk for Medicaid-funded institutionalization.

**In 1992 Wisconsin's NF bed ratio in 1992 was 75 NF beds per 1,000 persons age 65 and over, one of the highest in the nation.**

## Wisconsin's Long Term Care Service Program for Aged and Physically Disabled Persons

	<b>Services Provided</b>	<b>Annual Users</b>	<b>Av. Annual Expenditure Per User</b>	<b>Funding Source</b>
<b>Institutional care:</b>				
• Nursing Facilities	Nursing and personal care	30,497 (68.5%)	\$20,427	Medicaid
<b>Home &amp; community based care:</b>				
• Medicaid personal care and home health services	Personal care, home health	12,577	\$6,407 (average cost for aged & disabled)	Medicaid
• Medicaid waiver program	Supportive home care, respite care, chore & supervision services	6,129	\$6,371	Medicaid
• COP program	Any needed service	5,819	\$3,410	State
<b>All home &amp; community-based programs</b>		<b>14,000* (31.5%)</b>		

\* Approximately 14,000 users of home and community-based services is an estimated unduplicated count of beneficiaries, and cannot be obtained by adding the users of all home and community-based programs.

Through these programs, in 1992 Wisconsin served approximately 14,000 users in home and community-based care (31.5%), compared with an average daily census of 30,497 Medicaid-funded beneficiaries in nursing facilities (68.5%). About 12,500 received Medicaid home health and personal care services, while the Medicaid waiver program and COP each served about 6,000 aged or persons with physical disabilities. In 1992, direct service expenditures for the home and community-based programs totaled \$141 million, compared with expenditures of \$623 million for nursing facilities.

As noted, many people receive services from more than one home and community-based care program. Case managers deliberately enroll beneficiaries in multiple programs to provide a comprehensive package of services. For example, regular Medicaid and even the Medicaid waiver have service gaps that can be filled with services funded by the state's Community Options Program (COP).

By expanding home and community-based care, which is generally less expensive per person than institutional care, and by capping the number of nursing facility beds, Wisconsin has been able to constrain nursing facility utilization and moderate the rate of growth in expenditures. In this way, Wisconsin has been able to serve more long term care beneficiaries with available dollars. However, expansion of home and community-based programs has been limited by federal Medicaid waiver rules and state budget constraints. As a result, lengthy waiting lists have developed for all of Wisconsin's home and community-based long term care programs.



## Arizona's Long Term Care Delivery System

Arizona provides long term care services through the Arizona Long Term Care System (ALTCS) - under a 1988 amendment to its 1115 Waiver for the provision of acute care services to Medicaid eligible residents, which started in 1982. ALTCS is the first statewide capitated managed care system that combines Medicaid acute and long term care services. ALTCS provides acute care, behavioral health and long term care services to the elderly, the physically disabled, and people with developmental disabilities.

Enrollment in the managed care long term care system is mandatory. Members may select nursing facilities and home and community-based services based on their availability. The program is unique in that it was among the first to contract with managed care plans on a capitated basis for both acute and long term care services.

ALTCS serves people with a high level of functional impairment and health conditions. The state's nursing facility level of care criteria require a mix of ADL impairments, disorientation, behavioral problems, medical and nursing treatments and the presence of one or more health conditions. The high impairment levels require coordination of care between acute and long term care, and case managers with health care expertise.

- HCFA initially capped the number of elderly and disabled members who could receive home and community-based services, but ALTCS successfully negotiated to increase the cap from 5% to 40% of spending.
- With the higher cap, many members have transferred from nursing homes to community settings. To accommodate the housing needs of ALTCS members, legislative authority was obtained to expand options available through two pilot programs: (1) supported residential living centers; and (2) adult foster care homes.
- Capitation is based on cost estimates of nursing facility services, home and community-based services, case management, behavioral health services, acute care costs, and administrative/risk insurance costs. The capitation assumes 35% of the members will receive home and community based services, while 65% will receive services in nursing facilities.
- ALTCS attempts to promote better linkages between case management, acute care, behavioral health and long term care services which are bundled, but linkages are hindered by conflicts between Medicaid and Medicare laws and regulations.

As of October 1995, ALTCS enrolled 20,919 members. Of these, 10,325 were elderly, 3,225 had physical disabilities or chronic illness, and 7,369 were developmentally disabled. **Approximately 7,322 persons (35%) were receiving home and community-based long term care services, while 13,597 persons (65%) were receiving long term care services in nursing facilities.**

Appendix J, The Arizona Long Term Care System, contains a more complete explanation of Arizona's capitated managed care, acute and long term care system.

## • Trends In The Development Of Supportive Housing

Despite the obvious connection between long term care needs and housing options, long term care policies have generally been separate from policies on housing and social services. In the face of mounting costs for nursing facility care, however, that situation is changing. States are much more in linking housing and long term care services.

Supportive housing enables older persons who need some assistance, but do not require extensive medical supervision, to live as independently as possible. Such housing promotes "aging in place" because it assists residents with a range of service needs.

Many states are adopting strategies to reduce the need for additional nursing facility beds by encouraging the development of new types of supportive housing for elderly and disabled people. Some states offer incentives through housing loans, grants and subsidies, and they impose standards for these types of housing through licensing and regulation. A number of different supportive housing models are currently in use or are being developed for people who need assistance with long term care, including: (1) congregate housing, (2) adult foster care homes, (3) residential care facilities, and (4) assisted living facilities.<sup>6</sup>

### • **Congregate Housing**

Congregate housing refers to residential buildings with separate apartments and shared dining facilities and other community space. Congregate housing typically includes supportive services, such as housekeeping and transportation, plus one meal a day. This type of housing does not usually include personal care or protective supervision.

### • **Adult Foster Care Homes**

Adult foster care homes are non-medical living arrangements for five or fewer persons. Such homes are licensed by the state. The state usually recruits homes for participation in the program, trains staff, and encourages family members to run the homes. Clients pay for services directly, some supported by funding for services through Medicaid waivers.

### • **Residential Care Facilities**

Residential care facilities, also known as board and care homes, also provide rooms (often semi-private), shared common areas, meals, protective oversight, and some help with the activities of daily living. Many, but not all residents of residential care facilities are mentally ill. Accordingly, many residential care facility service components are designed for elderly persons who have cognitive deficits but do not have a skilled nursing need.

### • **Assisted Living Facilities**

Assisted living facilities provide both individualized personal assistance, often for people needing considerable help with many activities of daily living, as well as substantial oversight and supervision for residents with dementia. Assistance and supervision are available on a 24-hour basis. Assisted living, which offers private rooms or small apartments, is generally affordable only for persons who are able to pay privately.



• **HCFA Nursing Home Case Mix and Quality Demonstration Project**

The Nursing Home Case Mix and Quality Demonstration Project, funded in 1989 by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), Office of Research and Demonstrations, was initiated to design, implement and evaluate a combined Medicare and Medicaid nursing facility prospective payment and quality evaluation monitoring system across six states.

This Demonstration Project is designed to create a prospective payment system (PPS) for both Medicare and Medicaid payments for nursing facility services. Currently, the prospective payment indices are tied to 44 groups from Resource Utilization Groups (RUGS-III), and based on resident characteristics and medical needs. The goals of the project include improving quality of care, increasing access to services, and providing equity of payment to providers while maintaining budget neutrality and unaltered benefits across the Medicare and Medicaid programs. While these goals are quite ambitious, HCFA is clearly interested in revising payment systems in instances where there exists cost-based reimbursement.

The Demonstration Project includes differential payments for nursing facility services based on acuity. The term "case mix" refers to a "mixture of different types of residents with similar characteristics and service needs. If a resident has special or heavy care needs, the nursing facility would be reimbursed at a higher rate. If the resident's care needs are normal or lighter (needs less care), the nursing facility would be reimbursed at a lower rate.

By increasing reimbursement for higher acuity levels, HCFA believes access to nursing facility services will increase for higher acuity, or heavy care, patients. Given budget neutrality, reimbursement for lower acuity patients would decrease. This lower reimbursement may create an incentive to develop alternative methods of caring for lower acuity, or light care, patients. These methods might include home care, assisted living facilities, and other lower cost options.

While the Nursing Home Case Mix and Quality Demonstration Project may not be implemented in its current form, HCFA is developing a database that will likely influence federal health policy regarding nursing facility services. Ultimately, HCFA will probably revise the payment system and at least reduce the rate of expenditure growth. The target for a prospective payment system for nursing facility services will be sometime after 2000.

**Should it be implemented, a prospective payment system for nursing facility services may have an impact on the projected demand for nursing facility (NF) beds throughout the country. It could potentially result in an overall decrease in NF bed demand, due to the disincentive to provide nursing facility services for lower acuity patients in NF beds.**

Laguna Honda Hospital provides nursing facility level of care and assistance with ADLs to elderly and disabled patients, including medically complex, dementia, medical/psychiatric, AIDS, head trauma, rehabilitation, and developmentally disabled cases. The Jewish Home for the Aged provides nursing facility level of care and assistance to long term care patients. Acute care hospitals provide nursing facility level of care, and some subacute care, primarily to post-acute patients. Freestanding nursing facilities provide nursing facility level of care and assistance with ADLs to geriatric and disabled patients who require custodial care. Some freestanding nursing facilities provide subacute care for patients who are stable but require a higher level of care.

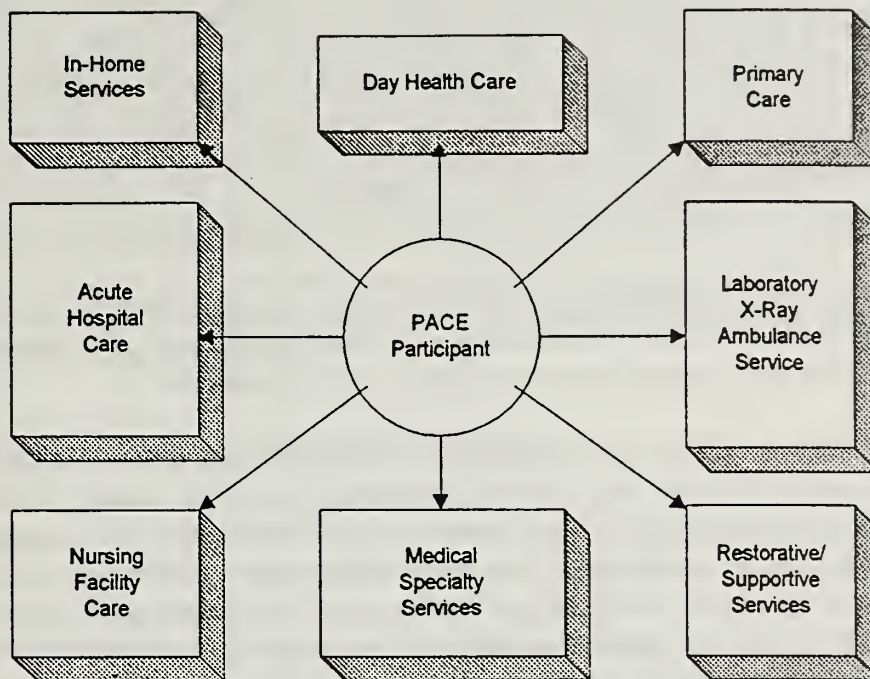
**Home and community-based services also provide long term care** for people who are recovering from an illness, elderly, disabled, suffering from a chronic condition, or chronically or terminally ill. Individuals can receive the health care services they need, including skilled care and assistance with ADLs, at home or in other residential settings, with additional help from other services available in the community. A variety of different kinds of home and community-based services exist to assist people requiring care and assistance at home. These include: attendant care services, homemaker services, home health care services, respite care services, adult social day care services, adult day health care services, comprehensive outpatient rehabilitation facilities, Alzheimer's day care resource centers, hospice services, transportation services, home delivered meal services, supportive housing and residential services, and case management services.

The PACE Program: innovative home and community-based long term care. One innovative home and community-based service provider is On Lok Senior Health Services, a Medi-Cal and Medicare managed care capitated program. On Lok's PACE Program (Program of All Inclusive Care for the Elderly) provides comprehensive and coordinated community-based health and social services to nursing facility certifiable elders. By providing a full continuum of care under a risk-based funding stream, PACE addresses the needs of the frail elderly who need long term care. PACE provides for:

- Lifetime service to the frail elderly who otherwise would have few options besides permanent institutionalization.
- Continuing support for participants through ongoing residence and involvement in the community.
- Comprehensive medical, restorative, psychosocial, and supportive services to respond to multiple and interrelated problems.
- Interdisciplinary teams for allocation and delivery of care, with service integration.

The PACE care model includes: (1) in-home services; (2) day health care; (3) primary care; (4) laboratory, X-ray, and ambulatory services; (5) restorative and supportive services; (6) medical specialty services; (7) nursing facility services; and (8) acute hospital care. PACE enrollees receive any of these health and social services deemed necessary by the interdisciplinary team. The team develops control treatment plans, and delivers most services in an adult day health center setting.





### **Program of All Inclusive Care for the Elderly (PACE)**

(All services are provided through a multi-disciplinary team)

The PACE program is able to provide comprehensive care for almost all individuals who are nursing facility certifiable. Out of approximately 430 people served at one of On Lok's PACE sites in San Francisco, only 20 people are in nursing facilities. Individuals who require institutional settings include: (1) the very frail; (2) agitated demented wanderers; (3) very physically dependent individuals who require two-to-three person transfers; (4) those who don't relate to their surroundings; (5) those who have no family support; and (6) those who have little or no financial resources.

On Lok's success with the PACE model led to the enactment of Congressional legislation in 1986 which authorized a demonstration project to replicate PACE's unique service delivery and financing model at up to 15 sites nationwide. Currently there are 10 PACE replication sites operating under dual Medicare and Medicaid waivers. An additional 10 sites are in Pre-PACE Medicaid capitation operations; moreover, 40 sites are in the process of feasibility study, or planning and development.

On Lok currently operates PACE programs at four locations which serve the east and south east portions of the City, including: (1) the 1333 Bush Street Center; (2) the 1441 Powell Street Center; (3) the 1000 Montgomery Street Center; and (4) the 225 30th Street Center. On Lok has four adult day health centers, a home health agency license, and contracts for acute hospital care with Saint Francis Memorial Hospital, St. Luke's Hospital, Chinese Hospital, and California Pacific Medical Center.

In collaboration with the Goldman Institute on Aging, On Lok has replicated its PACE program for nursing facility certifiable elders who live in previously unserved communities in the western portion of the City. The Institute on Aging (IOA) is now operating a PACE program, known as On Lok SeniorHealth by IOA/UCSF, at 1426 Fillmore Street. This collaboration, in addition to the other four PACE program sites, should provide access to comprehensive community-based health and social services for all frail elderly people in San Francisco who want integrated community services to provide their long term care.

The Multipurpose Senior Services Program (MSSP) and Linkages. The Goldman Institute on Aging also operates two state-funded community-based case management programs: (1) the Multipurpose Senior Services Program (MSSP), and (2) Linkages.

Under a federal Home and Community-Based Waiver, the primary objective of the MSSP program is to avoid or delay the inappropriate placement of people in nursing facilities, while fostering independent living in the community. MSSP provides services to eligible clients and their families to enable clients to remain in their homes. Services must be provided at a lower cost than that which would be required for nursing facility placement. This program is available free of charge to Medi-Cal recipients 65 or older who meet nursing facility eligibility criteria. Case management is the cornerstone of MSSP. Each client receives a complete in-home health and psycho-social assessment by a nurse and a social worker, a care plan, service arrangement, and ongoing monitoring. One of the largest of 22 such programs in California, MSSP serves a daily caseload of 400 clients.

California's Linkages program, begun in 1985 and paid for entirely with state general funds, is a case management program similar to MSSP, but focused on functionally impaired or frail persons 18 and older. There are no income criteria and clients do not have to be nursing facility eligible, but they must be at risk for institutionalization. Linkages is designed to assist individuals who do not qualify for any other state case management program. At the Institute on Aging, 40% of the Linkages clients are under age 65.

While the Institute on Aging's MSSP and Linkages programs have successfully reduced the number of inappropriate institutionalizations and saved taxpayer dollars, they have the potential to do more. These programs could serve as models for the integration of case management of both acute and long term care services. Keeping clients out of institutions may sometimes result in an increased use of acute care systems, the most expensive component of the health care system. Integrating acute and long term care case management might be a more effective method of lowering costs.

Other home and community-based long term care services. Many other organizations provide components of home and community-based long term care in San Francisco. Two are: (1) Visiting Nurses and Hospice of San Francisco, which provides skilled care, personal care, and chore services to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); and (2) In Home Supportive Services, which provides home health aides to assist people in the home with ADLs and IADLs, as well as with some personal care.



In addition, the San Francisco Commission on the Aging supports a variety of different programs - most provided by non-profit organizations - which provide components of community-based long term care including: (1) adult day health care services, to maintain the optimal capacity for self-care by older persons and the ability to live in the community rather than be placed in an institution; (2) home delivered meals and congregate meals programs, to maintain and improve the physical and social well-being of older persons through appropriate nutrition services; (3) in home supportive services, to assist older persons in their homes when confronted with difficulties performing ADLs or IADLs; and (4) the formation of Senior Centrals, which provide one-stop access to an expanded range of essential services and information.

## 2. Post-Acute Care Service Delivery

Medicare expenditures in the U.S. for post-acute and acute care are expected to rise substantially in relationship to the growing number of persons over age 65. Subacute care is being promoted as a cost-effective alternative to inpatient acute hospital care. The cost savings arguments are based principally on the fact that per diem costs in a subacute setting may be as much as 40 to 60% less than hospital acute care.<sup>7</sup>

### • The Growth In Subacute Care

The term "subacute care" was *in the past* used to describe hospitalized patients who failed to meet criteria for a medically-necessary acute stay. A 1986 national study of "Subacute Care in Hospitals" was commissioned by the Prospective Payment Commission (ProPAC). In that study, conducted in collaboration with the American Hospital Association, subacute care was defined as: **"Subacute care includes patients with a range of intensity of needs from those in the immediate post-acute period (including Medicare-reimbursed skilled care in nursing homes and home care) through those with minimal needs (including custodial level of care not reimbursed by Medicare)"** (Lewin ICF, 1988). The Lewin ICF report states that the ProPAC study "focused particularly on subacute patients in general acute care beds, including patients waiting for nursing home placement, swing bed patients, patients who chose to remain in the hospital after the acute episode of stay, and patients not formally admitted to acute care (e.g., patients staying in an acute care bed after outpatient surgery)."

However, the definition of subacute care has been changing. In its 1995 report "Subacute Care: Policy Synthesis and Market Area Analysis", Lewin VHI states: **"Based on the review of the literature, the site visits, and interviews with providers and experts, we found that many people used definitions of subacute care that included varying descriptions of patients, staffing, services, and/or settings. The current literature uses the term subacute care nearly exclusively to refer to patients treated in settings other than acute hospitals."** The Lewin VHI report also states: "When the term "subacute care" is used *in practice*, it nearly always refers to a set of patients whose needs fall somewhere between acute hospital care and "traditional" longer-term nursing facility care."

A wide range of patients are treated in subacute care settings: (1) traditional Medicare skilled patients; (2) ventilator dependent patients; (3) brain or head injury patients; (4) patients requiring orthopedic rehabilitation; (5) patients requiring cardiac rehabilitation; (6) post surgical care patients; and (6) wound care patients. The Lewin VHI report continues: "In practice, the care provided to these patients is increasingly referred to as subacute care. Thus, the term "subacute care" has come to refer to a level of care - skilled care for patients with complex needs - that some nursing facilities and home care providers have been providing for years under different names (e.g., "high-end skilled care", or "heavy care").

Medicare's payment systems for acute care have led to increased demand for post-acute care services for higher acuity patients. The Prospective Payment System (PPS) reimburses hospitals on a flat rate basis by diagnosis, which provides hospitals with financial incentives to discharge Medicare patients as quickly as possible. These Medicare payment policies for post-acute care have encouraged the growth of subacute providers. The reimbursement of subacute care providers is on a cost-related basis. When combined with the strong incentives for discharge from acute hospitals under PPS, this has led to both the demand for post-acute care services and an increasing supply of post-acute care providers.

The 1986 ProPAC study reported a trend, which was the increasing development of distinct part, PPS-exempt units in hospitals to care for newly identified subacute patients, and the related development of increasing capacity (or need) to care for more acutely ill, post-acute patients in freestanding nursing facilities and other settings.<sup>8</sup> The Lewin VHI report notes that institutional subacute care providers, particularly nursing facilities, have been a driving factor in the development of subacute care options recently. Settings in which subacute care is provided include: (1) subacute units; (2) hospital-based and freestanding nursing facilities; (3) rehabilitation facilities; (4) stepdown units; (5) subacute rehabilitation facilities; or (6) transitional living facilities.

The Lewin VHI report also notes that providers consistently distinguish between "rehabilitation subacute" and "medical subacute". The report states: **"Rehabilitation subacute" refers to patients with orthopedic conditions, such as hip replacement, spinal cord injuries, and brain injuries. These patients tend to require more rehabilitation services such as physical, occupational, and speech therapies. Conversely, "medical subacute" patients tend to have conditions that require intensive medical and nursing care, but fewer other therapies. These patients include those with cardiovascular diagnoses, cancer, ventilator care, wounds, and IV therapy."**

The trend toward subacute rehabilitation. Hospital-based rehabilitation is being curtailed in markets with a high degree of managed care penetration. In addition to the traditional inpatient program, the "rehabilitation continuum of care" increasingly includes a subacute program, an outpatient program, and a home-based program. This array of rehabilitation settings is being driven by costs, particularly the cost of traditional inpatient rehabilitation.



In many instances, managed care payers are bypassing acute inpatient rehabilitation altogether, insisting that patients traditionally seen in acute inpatient programs obtain rehabilitation in subacute units. Older patients with a stroke or hip fracture are placed in subacute settings instead of acute inpatient settings. In highly managed care markets, some acute inpatient programs are being reserved for persons with severe traumatic brain injury, spinal cord injury, and younger persons with stroke.

As the utilization of acute inpatient rehabilitation units has declined, subacute rehabilitation has become the new growth industry in highly managed care markets. The growth of subacute rehabilitation appears to be the result of two sources of sponsorship: (1) traditional acute inpatient providers have begun to offer a subacute alternative; and (2) existing nursing facilities have added a rehabilitation component in response to what is seen as a new market opportunity. Many rehabilitation providers are experiencing these trends in highly managed care markets. As a result, traditional hospital-based acute rehabilitation is no longer considered the focal point of a rehabilitation service delivery system.

The trend toward stepdown units. Some hospitals are finding stepdown units can provide appropriate care for patients found in intensive care units (ICUs). ICUs are often the most expensive medical services a hospital offers. Advances in medical technology to maintain life in the presence of life threatening illness have increased the use of ICU beds. New strategies to provide high quality, cost effective care, particularly in the framework of managed care, have resulted in the creation of stepdown units for first-day post operative coronary artery bypass graft patients, cardiac surgery patients, and patients on IV infusions. Patients admitted to a stepdown unit for an average length of stay of 1.99 days reduced length of stay in the ICU by 1.36 days. A shorter length of stay in the ICU resulted in reduced hospital charges.<sup>9</sup>

The Lewin VHI report states: “The largest percentage growth in the U.S. from 1986 to 1994 in subacute care providers was in hospital-based nursing facilities, which grew from 652 in 1986 to 1,953 in 1994, an increase of 200 percent.” The authors believe this growth of hospital-based nursing facilities is in response to the strong incentives hospitals have to discharge patients and, as length of stay and utilization rates fall, convert empty acute beds to NF beds to capture cost-based reimbursement for the patient’s post-acute care.

- **California’s Subacute Care Program**

The Medi-Cal program instituted a subacute classification of care in 1986, which is called the **Adult Subacute Care Program**. The care provided under this program is technology dependent, has no limit on length of stay, and is provided in nursing facilities that contract with the California Department of Health Services (DHS). As defined by the DHS, the program’s mission is: “To provide access to quality medical care for a subgroup of Medi-Cal beneficiaries requiring medically necessary services beyond the capability of a nursing facility level of care.”

Criteria for the adult subacute care program include: (1) the patient's condition has stabilized to the point that acute care is not medically necessary; (2) the patient's condition warrants 24-hour nursing care by an RN; and (3) medical necessity includes, but is not limited to: a tracheotomy; administration of total parenteral nutrition; inpatient PT, OT, or ST; tube feeding; inhalation therapy; continuous IV therapy; and wound care. Providers must be licensed as distinct part nursing facility in a general acute care hospital, or as a freestanding nursing facility. Currently, Medi-Cal reimburses subacute care in hospital-based nursing facilities at a higher rate per patient than freestanding nursing facilities.

• **California's Transitional Inpatient Care Program**

California is expanding subacute services through the creation of the **Transitional Inpatient Care (TIC) Program** by the California Department of Health Services (DHS). As defined by the DHS, the program's mission is: "To provide access to quality *medical* and/or *rehabilitative* care to a subgroup of Medi-Cal beneficiaries requiring medically necessary services who are medically stable with short-term transitional care needs."

Criteria include: (1) the patient is 18 years of age or older; (2) the patient's condition has stabilized to the point that acute care is not medically necessary; (3) the physician responsible for treatment management of the patient has developed a definitive and time-limited course of treatment; and (4) medical necessity includes: continuous or intermittent IV therapy; total parenteral nutrition; IV pain management; IV hydration; inpatient physical, occupational, or speech therapy; wound care; respiratory therapy, traction; and other medical/rehabilitation treatments. Providers must be licensed as a general acute care hospital with distinct part nursing facility, or a freestanding nursing facility.

San Francisco hospitals with distinct part nursing facilities and freestanding nursing facilities have begun to expand their subacute care capabilities. Three nursing facilities operate subacute units in accordance with the requirements of the Adult Subacute Care Program.

- St. Luke's Hospital - 40 bed subacute unit
- Seton Medical Center - 44 bed subacute unit
- Nobb Hill Health Care Center - 21 bed subacute unit

More recently in the San Francisco market area, six nursing facilities have been approved by the State Department of Health Services to receive reimbursement for transitional inpatient care in accordance with the Medi-Cal requirements of the Transitional Inpatient Care Program. One additional application has been submitted as of July 1996.

- California Pacific Medical Center - 11 TIC beds
- Saint Francis Memorial Hospital - 10 TIC beds
- St. Luke's Hospital - 20 TIC beds
- Laguna Honda Hospital - 5 TIC beds
- San Francisco General Hospital - 2 TIC beds
- San Francisco Community Convalescent Hospital - 10 TIC beds
- Chinese Hospital - application pending as of July 1996



### **Section 3.**

#### **The Future Demand For Total Long Term Care**

### **Section 3. The Future Demand For Total Long Term Care**

This section defines the future demand for total long term care by examining the needs of the whole population. Section 4, which will complete the demand analysis, will specifically focus on the future demand for NF beds for long term care services.

The future demand for total long term care in the U.S. and San Francisco will be based on the needs of specific groups, including: (1) elderly persons; (2) persons with disabilities; (3) persons with chronic conditions; (4) persons with AIDS; and (5) terminally ill persons. While many individuals within each of these groups will require long term care, reliable population projections are only available for elderly persons (the vast majority of the defined population).

This analysis will present national, state and local demographic trends for the elderly. It will project the size of this population in San Francisco, and then estimate the number of elderly who will require long term care for 2000, 2010, and 2020. Because insufficient information is available for the other groups, and because some groups overlap with the elderly, it is not possible to project long term care demand for the non-elderly for future years. However, each group will be described and trends related to care will be presented.

#### **1. Elderly Persons**

##### **National Trends**

According to federal projections, the nation's elderly population will increase significantly in the next 25 years. Projections released by the U. S. Census Bureau indicate that the national senior population will increase by two-thirds from today's 32.7 million to 53.3 million by 2020. Eight states are expected to double their elderly populations (persons 65 and over) by 2020 as follows:

**U.S. Census Bureau Projections for States  
With Doubling Elderly Populations (65 and over) by 2020**

	1993	2020	Percent Change
Nevada	155,000	333,000	115.6%
Arizona	529,000	1,121,000	111.9
Colorado	357,000	743,000	108.0
Georgia	695,000	1,419,000	104.0
Washington	612,000	1,245,000	103.5
Alaska	26,000	54,000	103.3
Utah	165,000	334,000	102.4
California	3,303,000	6,622,000	100.5

There are several different groups of elderly, each with different health care needs. Due to the increase in numbers, there is going to be a heightened demand for services for the elderly. Those 85 and over will be the fastest growing segment of the elderly population, with numbers rising in the U.S. from approximately 3 million now to 7 million by 2020.

During the 20-year period from 1990 to 2010, the elderly population will grow at a lower average annual growth rate than during any similar period since 1910. This low rate of growth is directly related to the low fertility of the 1930's. The growth in this period will be slight, relative to the approaching substantial elderly growth during the period between 2010 and 2030. The coming high growth is the result of the entrance of the Baby-Boom cohorts into the 65 and over age category. While the high annual growth rate of the 2010 to 2030 period is not without precedent, there will be an unparalleled increase in the absolute number of elderly persons in the United States.<sup>10</sup>

### **State Trends**

According to the U.S. Census, California's elderly population will be the largest in the nation. Its size will double from approximately 3.303 million residents 65 years or more in 1993 to 6.622 million in 2020. This increase in the State's elderly population represents a 100.5% change. Census data shows by 2000, persons 65 and over will comprise 10.6% of the state population. By 2010, this group will comprise 11.2% of the state population. By 2020, this group will comprise 13.8% of the state population.

Of the elderly in California in 2020, the Census projects the oldest old (persons 85 and over) will increase by 486,000 - a 151% change from the 1993 figure of 323,000. By 2000, it is projected that 418,000 of the total state population will be 85 years and over. By the 2010, this number will increase to 636,000. By 2020, this number will increase further to 809,000. The table below shows the increase in the population 65 years and over, and 85 years and over. Percents in the table are of un-rounded numbers.

#### **U.S. Census Bureau Projections for California**

	<b>2000</b>	<b>2010</b>	<b>2020</b>
population total	34,888,000	41,850,000	47,953,000
persons 65 and over	3,704,000 (10.6%)	4,605,000 (11.2%)	6,622,000 (13.8%)
persons 85 and over	418,000 (1.2%)	636,000 (1.5%)	809,000 (1.7%)

The following table presents the projections made by the State Department of Finance for California's elderly population. These projections are higher than the projections made by the U.S. Census Bureau.

#### **State Department of Finance Projections for California**

	<b>2000</b>	<b>2010</b>	<b>2020</b>
population total	36,443,857	42,408,137	48,976,518
persons 65 and over	3,953,482 (10.8%)	5,002,475 (11.7%)	7,246,854 (14.8%)
persons 85 and over	507,120 (1.4 %)	765,368 (1.8%)	940,118 (1.9%)



## Local Trends

State Department of Finance census figures as of April 1, 1990, show the City's population at 723,959. There were 137,748 persons 60 and over (19 % of the City's total population), and 105,380 persons age 65 and over (14.6 % of the City's total population). The percentage of persons 65 and over statewide was 10.5%. A total of 57,270 persons were between 65-74, and a total of 35,962 persons were between 75-84. **The 1990 census shows the population of persons 85 and over was 12,148 persons (1.6% of the City's total population).**

Data from the S. F. Commission on the Aging shows the over 60 population in 1990 was 46.2% ethnic/racial minorities. The largest group was Asian/Pacific Islander (27.3%), then African American (9.5%), Hispanic (9.1%), American Indian, Alaskan Native or Aleut (.2%), and Other (.1%). The remainder, or 53.8%, was White.

By 2000, the number of persons 65 and over is projected to increase to 116,080 (15% of the City's total population). This represents a projected cumulative increase (over the April 1, 1990 census) of 10,700 persons over 65. But the fastest growing age group is expected to be those 85 and over. Seniors ages 75 to 84 will increase by 5,780, which is an increase of 16% by that date, but those 85 and over will increase by 46%. This represents a projected cumulative increase of 5,570 persons over the age of 85. **The population of persons 85 and over by 2000 is projected to be 17,718 persons (2.3%).**

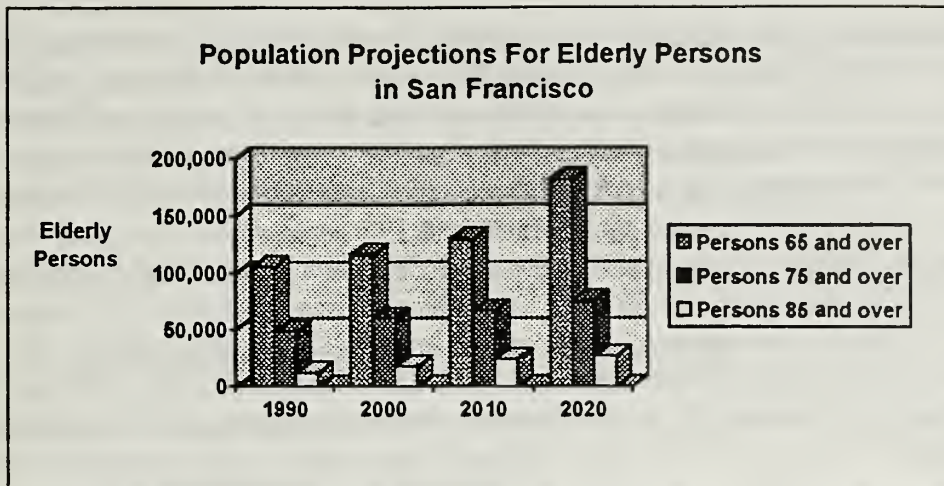
By 2010, the number of persons 65 and over is projected to increase to 129,787 (16.6% of the City's total population). This represents a projected cumulative increase (over the April 1, 1990 census) of 24,407 persons over the age of 65. Seniors ages 75 to 84 will increase by 6,563 persons, which is a cumulative increase of 18.2% by that date. Seniors 85 and over will increase by 97% (over the April 1, 1990 census). This represents a projected cumulative increase of 11,810 persons over the age of 85. **The total population of persons 85 and over by 2010 is projected to be 23,958 persons (3.1%).**

By 2020, State projections show persons age 65 and over should increase to 181,981 (23.4% of the City's total population). This represents a projected cumulative increase of 76,601 persons over 65 (again, over the April 1, 1990 census). Seniors ages 75 to 84 will increase by 12,552 persons, which is a cumulative increase of 35% by that date. Seniors 85 and over will rise even more dramatically - by 121% (over the April 1, 1990 census). This represents a projected cumulative increase of 14,684 persons over 85 by 2020. **The total population of persons 85 and over by 2020 is projected to be 26,832 persons (3.4%).**

### **State Department of Finance Projections for San Francisco**

	<b>2000</b>	<b>2010</b>	<b>2020</b>
Population total	774,011	781,735	777,391
persons 65 and over	116,080 (15.0%)	129,787 (16.6%)	181,981 (23.4%)
persons 75 and over	59,523 (7.70%)	66,483 (8.50%)	75,346 (9.69%)
persons 85 and over	17,718 (2.30%)	23,958 (3.10%)	26,832 (3.40%)





Demand for Long Term Care generated by Elderly Persons. Due to the increasing size of the elderly population, the long term care need for this group will continue to grow. But predicting the amount of growth is complicated. While the number of future elderly is expected to drive up demand for services, no consensus exists on the size of the increase due to different assumptions about the future prevalence of disability. Changes in death and disease rates for the elderly will affect the need for long term care.

Some researchers argue that medical advances have increased life expectancy but have not changed the onset of illness. They predict declining death rates may actually increase long term care need if more people live to develop age-related disabling conditions such as Alzheimer's disease, or live longer with existing disabilities. Other researchers argue that disability is becoming increasingly compressed into a shorter portion of the lifespan, decreasing the number of years long term care is needed. Improved treatments or prevention of common disabling conditions among the elderly, such as strokes and heart disease, could lessen long term care need, independent of death rates.

Indicators of demand for long term care by the elderly. The precise number of elderly persons that will require long term care in the future is difficult to project. However, there are several indicators, based on both national and local experience, that can be used in estimating the potential demand.

Predictor Number 1. One predictor of the need for long term care in older adults is the number of persons with mobility limits or self care limits. Recent Claritas demographic data show **9.7% of the population 65 and over living in the community in San Francisco in 1990, approximately 9,896 persons, had both mobility and self care limits.** By carrying this percentage forward, it can be estimated that: (1) 11,296 persons 65 and over living in the community with both mobility and self care limits may need some kind of care in 2000; (2) 12,589 persons 65 and over living in the community with both mobility and self care limits may need some kind of care in 2010; and (3) 17,652 persons 65 and over living in the community with both mobility and self care limits may need some level of care in 2020.

Predictor Number 2. Another predictor of the need for long term care in older adults is the number of people over age 85, the frail elderly, who will need assistance with the activities of daily living (ADLs). People 85 and older have the greatest need for long term care. **While 10.5% of persons 65 to 74 in the U.S. required assistance with ADLs in 1990, over 51% of persons 85 and over needed help with ADLs.**<sup>11</sup> Based on this nationally estimated percentage, approximately 6,195 persons over the age of 85 in San Francisco in 1990 would have needed assistance with one or more activities of daily living. By carrying this percentage forward, it can be estimated that: (1) 9,036 persons over the age of 85 will need assistance with one or more ADLs by 2000; (2) 12,128 persons over the age of 85 will need assistance with one or more ADLs by 2010; and (3) 13,684 persons over the age of 85 in San Francisco will need assistance with one or more ADLs by 2020.

Predictor Number 3. Locally, On Lok Senior Health Services considers the over 85 age group as one of the best predictors of the need for long term care in older adults, and estimates **at least 10% of persons 85 and over may require comprehensive long term care services.** Based on this locally estimated percentage, at least 10% of San Franciscans in 1990 over the age of 85, or approximately 1,215 persons, would have required long term care services. Carrying this percentage forward, it can be estimated that: (1) at least 1,778 persons over 85 may need comprehensive long term care services in 2000; (2) at least 2,396 persons over 85 may need comprehensive long term care services in 2010; and (3) at least 2,683 persons over 85 may need comprehensive long term care services in 2020.

### **The Demand for Total Long Term Care for the Elderly Projected to 2000, 2010 & 2020**

These above indicators suggest the demand for total long term care by San Francisco's elderly population can be projected to fall in the following ranges for the periods ending in the years 2000, 2010, and 2020:

**By 2000, approximately 11,296 persons 65 and over, living in the community with both mobility and self care limits, may need some level of care. Approximately 9,306 persons age 85 and over - the frail elderly - may need assistance with ADLs. At least 1,778 persons in this group may need comprehensive long term care services. Additional persons between 75 and 84 will begin to need help with ADLs.**

**By 2010, approximately 12,589 persons 65 and over, living in the community with both mobility and self care limits, may need some level of care. Approximately 12,128 persons age 85 and over - the frail elderly - may need assistance with ADLs. At least 2,396 persons in this group may need comprehensive long term care services. Additional persons between 75 and 84 will begin to need help with ADLs.**



By 2020, approximately 17,652 persons 65 and over, living in the community with both mobility and self care limits, may need some level of care. Approximately 13,684 persons age 85 and over - the frail elderly - may need assistance with ADLs. At least 2,683 persons in this group may require comprehensive long term care services. Additional persons between 75 and 84 will begin to need help with ADLs.

### Indicators of Demand For Total Long Term Care for the Elderly

Indicators of Demand	2000	2010	2020
<u>Indicator Number 1:</u> Persons 65 and over with mobility and self-care limits, living in the community, who may need some level of care (9.7% of persons 65 and over).	11,296	12,589	17,652
<u>Indicator Number 2:</u> Persons 85 and over - the frail elderly - who may need assistance with activities of daily living (51% of persons 85 and over).	9,306	12,128	13,684
<u>Indicator Number 3:</u> Persons 85 and over - the frail elderly - who may require comprehensive long term care services (10% of persons 85 and over).	1,778	2,396	2,683

## 2. Persons with Disabilities

A disability is defined as a limitation in actions and activities because of mental, physical, or emotional health condition. Limitation in actions range from relatively minor limitations, such as difficulty seeing at night to relatively major ones, such as being unable to work or needing assistance from another person in self-care activities. A functional impairment is a temporary or permanent disability, resulting from injury or sudden trauma, aging, disease, or a congenital condition, which limits a person's ability to perform one or more activities of daily living, including but not limited to: dressing, bathing, grooming, getting around inside and outside the home, eating prepared meals, shopping, cleaning, communicating, and performing cognitive tasks such as solving problems and processing information.

Nationally, about 12 million persons aged 16 and over are estimated to have some difficulty in outside mobility or self-care. At age 65 and over, the rate of having an outside mobility or self-care limitation is over four times the rate at ages 16 to 64.

Of these 12 million Americans - young and old - who report some long term care need, more than 5 million are estimated to be severely disabled. While most of the 12 million are elderly, 40% are not, and, regardless of age, most of the care that they need is non-medical assistance with the routine activities of daily living.

The number of nonelderly disabled has grown consistently in recent years. Possible explanations for the growth in the nonelderly disabled population include better medical technology and improved access to acute care, both of which may enable people to survive previously fatal conditions while sustaining permanent disabilities. Estimates of future long term care need among nonelderly disabled persons are difficult to project. Less information is available on which to base predictions about disability among the nonelderly, and small changes in how frequently certain disabling conditions occur among the nonelderly can significantly affect the numbers needing long term care. However, most researchers believe the size of the nonelderly disabled population is likely to increase.

People with disabilities, who have functional impairments and who believe they are able to live independently, generally prefer home and community-based settings over institutionally based settings. As noted in the Section of this Study on trends, in addition to inpatient rehabilitation, the rehabilitation continuum of care increasingly includes a subacute program, an outpatient program, and a home-based rehabilitation program.

### **3. Persons with Chronic Conditions**

A chronic condition is one that lasts over many years, cannot be cured, and often is associated with disability. Chronic conditions include: (1) deformities or orthopedic impairments; (2) arthritis and rheumatism; (3) heart diseases; (4) cerebrovascular disease; (5) pulmonary disease; (6) multiple sclerosis; (7) emphysema; (8) chronic sinusitis; (9) hay fever or allergic rhinitis; (10) prostate disease; (11) diabetes; (12) senile dementia or organic brain syndrome; (13) essential hypertension; (14) deafness; and (15) depression. Persons of all ages experience high rates of chronic conditions. Approximately 52% of all severely or chronically disabled persons in the United States are seniors, while 48% of this population is under the age of 65. The prevalence of chronic conditions varies by age. For example, chronic sinusitis and bronchitis are prevalent in children under 18; arthritis, deafness, and high blood pressure are prevalent in adults over 45; and cataracts as well as senile dementia are primarily chronic conditions of adults over 75.

**Substantial growth is expected in the number of persons with chronic illness. More than four out of five persons 65 and older have at least one chronic condition. As the number of older adults is expected to rise to 53.3 million by 2020, the number of persons with one or more chronic conditions is anticipated to increase dramatically.**

Chronic conditions are also becoming more prevalent among subgroups of younger people. For example, there was a 159% increase in the number of working age people experiencing severe disabilities between 1959 and 1984. This increase can be attributed to a decline in mortality rates for certain conditions, such as heart disease and hypertension, which increases the prevalence rates for these disability conditions.

Similarly, improvements in trauma care and emergency medicine have decreased mortality rates for individuals with major physical impairments such as spinal cord injury, again increasing their prevalence in the non-elderly population. Further changes in the composition of those in need of long term care are arising from recent developments in the epidemiology and treatment of person with HIV disease.<sup>12</sup>



The diagnosis and treatment of chronic conditions is made more complex because many individuals often experience more than one chronic condition at once. For example, of the 20 million persons in the U.S. over 55 who have arthritis, 16% also have heart disease, 48% also have hypertension, 11% also have cancer, and 11% also have diabetes.<sup>13</sup>

Hospital discharge data show that four of the top seven reasons for hospital admissions relate to, or are complicated by chronic conditions. These include ischemic heart disease, pneumonia and influenza, cerebrovascular disease, and bone fractures.<sup>14</sup> Nursing facility use and high rates of chronic disease are strongly related. Between August 1985 and January 1986, the number of conditions per 1,000 nursing facility residents was:

241 per 1,000 for ischemic heart disease
234 per 1,000 for senile dementia or organic brain syndrome
182 per 1,000 for cerebrovascular disease
179 per 1,000 for arthritis and rheumatism
156 per 1,000 for essential hypertension
152 per 1,000 for other heart disease

Source: Collins, 1993.

Because chronic conditions are dynamic and last for years, individuals needing chronic care services often obtain them from a variety of settings. For instance, an individual with heart disease may require physician care, hospital care, subacute care, nursing home care, home health care, rehabilitation care, and mental health services. the predominant pathway that people follow is to the physician and back home again. The relationship between home health, hospital, and nursing homes is also significant, with thousands of persons moving between these settings each year.<sup>15</sup>

**The National Chronic Care Consortium believes the majority of health and related services will be needed by and provided to older persons and others with chronic conditions. The Consortium anticipates that conditions such as Alzheimer's disease and severe arthritis are going to dominate all of health care, including services in hospitals, primary care clinics, and long term care delivery systems. Hospitals, nursing facilities, and community-based long term care providers are becoming increasingly interdependent in serving a common chronically impaired population.**

Chronic care is a common concern for both acute and long term care. The Chronic Care Consortium considers it an umbrella concept that means the ongoing provision of medical, functional, psychological, social, and environmental support which enable persons with serious, persistent chronic conditions to optimize functional independence and well-being.

The Consortium believes chronic care requires adoption of a prevention-disability focus that takes into account the natural evolution of chronic conditions as it evolves over time. Cumulative costs and quality of life for persons with chronic conditions are dependent on the array of primary, acute, transitional, and long term care service providers working together to bring prevent, delay, or minimize disability progression.

#### **4. Persons with AIDS**

AIDS is a chronic disease, and it continues to be a terminal disease. AIDS is included as a separate category of demand for long term care services due to the size of the AIDS population in San Francisco. The large number of persons with AIDS requires that it be considered a significant component long term care demand for the foreseeable future.

An estimated 600,000 to 900,000 persons in the country have been infected with the HIV virus in the 16 year history of the disease. This means that as many as one in 300 adult Americans has HIV, according to the federal Centers for Disease Control and Prevention. To date, more than 343,000 persons have died of AIDS throughout the United States.

California ranks second in the nation in the number of AIDS cases, and eighth in the nation based on incidence per 100,000 people. As of March 31, 1997, there have been 99,908 persons diagnosed with AIDS in California. Also, as of March 31, 1997, California had 35,771 persons living with AIDS. Los Angeles and San Francisco are most heavily affected by the epidemic, and well over half of all cases were diagnosed in these two counties.

As of March 31, 1997, 24,053 persons had been diagnosed with AIDS in San Francisco, accounting for one fourth of all cases reported in California, and 5% of all cases reported in the United States. San Francisco has one of the highest rates of new cases among major U.S. cities, and has the highest cumulative incidence of AIDS of all California counties.

NOTE: In May 1997, the 1997 HIV Prevalence and Incidence Consensus Meeting was held to determine the best possible estimate of existing and new cases of HIV infection in the city. Preliminary findings demonstrate that approximately 15,000 men, women and children in San Francisco have HIV disease, or 2.1% of the population.

As of March 31, 1997, approximately 7,335 persons were living with AIDS in San Francisco. No projections exist concerning the number of persons who will be living with AIDS in the city in the future. However, while the number of new cases and the number of deaths have decreased in 1996 and 1997, the number of persons living with AIDS has continued to rise. Assuming that between 7,000 to 7,500 persons with AIDS will be living in San Francisco, those who may require some type of care will be individuals with less than 200 T cells and who have one or more opportunistic infections.

Community-based settings for persons with AIDS. Many persons with AIDS who need long term care reside in the community, in shelters, or supportive housing programs.

Persons live in their own homes, or in residential settings with supportive services, including: (1) Peter Claver Community; (2) Richard M. Cohen Residence; (3) Catholic Charities - 1594 Market Street; (4) Guerrero House; (5) Rafiki House; (6) Fergeson House; (7) New Place; (8) Walden House; (9) Salvation Army - Harbor Light ; (10) Lodestar House; (11) Western Addition Recovery House; (12) Restoration House; (13) Maitri - a residential care facility; (14) Coming Home Hospice; and (15) Zen Guest House Hospice.



New residential programs have been developed for persons with AIDS, such as Leland House, which includes 45 beds - 10 of which will provide for high level nursing care. Visiting Nurses and Hospice of San Francisco provides home health care and hospice services to persons with AIDS who reside all throughout San Francisco. As of March 1997, the waiting list for housing options contained approximately 410 persons for placements and 4,078 persons for subsidies.

Nursing facilities caring for persons with AIDS. The number of AIDS patients placed in institutional long term care settings, either in hospital-based nursing facilities or freestanding nursing facilities, decreased dramatically in late 1996 and early 1997. This is due to several factors, including: (1) the opening of an increased number of community-based residential facilities that provide high level care; and (2) the recent significant positive impact of new AIDS drug treatments on the health status of persons with advanced HIV disease.

Trends in Treatments for AIDS and their impact on the demand for long term care. Several factors will influence how many persons with AIDS will need long term care and, of that number, how many will require nursing facility care. The primary factor is the advent of new effective treatments. As a result of recent advances in understanding of HIV infection, and because of more potent anti-viral drugs, treatment regimens are shifting for many persons with AIDS in San Francisco and throughout the United States.

Favorable test results of new anti-viral drugs were presented at the 11th International Conference on AIDS in Vancouver, B.C. in July 1996. The new drugs, known as protease inhibitors, have been on the market for several months. Taken in combination with older AIDS medications, they already appear to work far better than any treatments previously devised. In many patients, these drugs are removing all detectable traces of HIV from the blood, dramatically improving patients' health. So far, results have persisted for up to one year in at least 85% of treated patients. However, the long term impact of such treatments is not yet known.

The future demand for long term care for persons with AIDS. Despite these developments, across the country it is unclear who will get this treatment due to: (1) its high cost; and (2) the difficulty in maintaining arduous medication regimens. In San Francisco, these drugs are covered by the AIDS Drug Assistance Program. Many are being treated. However, there will be some who will not be treated, who will not be treated sufficiently early to save their immune systems, or who will be treated but cannot tolerate the side effects of these medications over an extended period. Accordingly, it is unclear how this and other treatments will impact the demand for long term care for all persons with AIDS.

**Advances in treatment may mean that some persons with AIDS will experience a compression of morbidity. Many individuals may live healthier lives for a longer period of time. Complications and opportunistic infections may be delayed. As a result, some persons with AIDS may not require institutional care to the degree they have in the past. This may reduce demand for acute care and nursing facility care.**



However, there will continue to be persons with AIDS who are multiply diagnosed - with AIDS, mental illness and substance abuse, who will require long term care. In addition, dynamic changes have taken place in the demographics of the epidemic in San Francisco. AIDS is now moving into poorer, more disenfranchised communities of color including African-American, Latino, and Asian/Pacific Islander gay and bisexual men, and increasing numbers of young injection drug users. Some of these persons may also require long term care.

Although the majority of AIDS cases continues to be made up by whites, their proportion has declined from 85.7% in 1981-85, to 72.6% in 1991-95. While AIDS diagnoses among gay and bisexual men accounted for 75.4% of new cases through August 1995, later groups have experienced an increase in their proportion of cases including injection drug users, men of color, women, and younger gay men. Heterosexual drug users, who comprised only 2.7% of all AIDS cases during the 1980s, account for 8.3% during the 1990s.

The age distribution of AIDS cases in San Francisco has also changed over the course of the epidemic. The first cohort of gay and bisexual men were mostly white and in their 30s and 40s. Younger cohorts became infected in the late 1980s and 1990s. Many of this younger group will not develop AIDS for several years.

Several risk populations have mini-epidemics. A survey of homeless gay and bisexual men, sampled from shelters and single room occupancy (SRO) hotels, found an HIV infection rate of 40%. A study of 2,000 HIV-infected individuals found that 25% are homeless or in marginally secure housing shelters or SRO hotels. HIV-infected women and transgender individuals are even more likely to be homeless or marginally housed. There is also a large group of runaway youths who migrate to San Francisco, who are gay, bisexual, and/or sex workers. A recent study estimated that 10% of gay and bisexual youths are HIV-infected. The HIV seroprevalence rate is over 40% for homeless youth identifying as gay or bisexual.

In the future, these other persons with AIDS whose disease will be progressing, may represent an increasing demand for long term care. This includes persons who: (1) have multiple diagnoses, (2) cannot tolerate aggressive treatments, (3) cannot maintain arduous medication regimens, (4) have had unsuccessful treatments, (5) have no support systems or stable housing, and (6) have little or no financial resources. This group may need a range of different housing options with supportive services including residential care facilities that provide long term care as well as hospice care, and also institutional nursing facility services.

## 5. Terminally Ill Persons

Terminally ill persons constitute a portion of the demand for long term care. Public health and clinical medicine during this century have given Americans the opportunity to live longer and more productive lives, despite progressive illness. For some patients, however, this progress has resulted in prolonged dying, accompanied by substantial emotional and financial expense. Many Americans today fear they will lose control over their lives if they become critically ill, and their dying will be prolonged and impersonal.

For a variety of reasons, some persons with terminal illness receive inpatient hospital care during the last stage of life. Other persons with terminal illness receive hospice care during the last stage of life. Although most hospice care is provided in the home by a licensed home health agency, an increasing number of hospitals and nursing facilities are providing hospice care in institutional settings.

Hospice programs provide palliative care, which focuses on pain control and symptom management, as opposed to curative care. Hospice care include supportive social, emotional and practical services for the terminally ill person, as well as support for the person's family. In addition, personal care, intermittent skilled nursing care, and 24-hour supervision are provided. Hospice care relies on the combined knowledge and skills of an interdisciplinary team of professionals - physicians, nurses, medical social workers, therapists, and counselors, in addition to volunteers - who coordinate an individualized plan of care for each patient and family. Hospice reaffirms the right of every person and family to participate fully in the final stage of life.

Congress enacted legislation in 1982 creating a Medicare hospice program. Hospice services may be provided to terminally ill Medicare beneficiaries with a life expectancy of six months or less. **Medicare hospice participation has grown at a dramatic rate, largely as a result of a 1989 congressional mandate to increase rates by 20%. From 1984 to 1995, the total number of hospices participating in the Medicare program rose from 31 to 1,857. Of the 1,857 Medicare-certified hospices, 699 are home-health agency-based, 460 are hospital-based, 19 are nursing facility-based, and 679 are freestanding.**

In 1994, 37 million aged and disabled persons were enrolled in the Medicare program. It is estimated that approximately 222,000 enrollees received hospice services, which is more than triple the number of hospice recipients in 1990. Along with the growth of Medicare-certified hospices, there are concomitant increases in Medicare's total reimbursement to hospices. **The Hospice Association of America anticipates the need for Medicare-certified hospices will continue to rise due to the growing aging population, the increasing number of persons with AIDS, and the rising health care cost. More importantly, medical professionals, as well as the general public are choosing hospice care over other forms of health care delivery for the last stage of life because of its holistic, patient-family centered philosophy.**





## **Section 4.**

### **The Future Demand for Nursing Facility (NF) Beds**

## **Section 4. The Future Demand for Nursing Facility (NF) Beds**

This section focuses on the future demand for NF beds for institutional long term care services. It includes: (1) a brief summary of persons who will comprise the demand; (2) the demand for NF beds projected to 2000, 2010 and 2020; and (3) the demand and supply of NF beds projected to 2000, 2010 and 2020.

The future demand for NF beds in the U.S. and San Francisco will be comprised of the needs for: (1) short term traditional nursing facility care; (2) short term subacute care (including medical subacute and rehabilitation subacute care, other types of stepdown units, and transitional inpatient care); and (3) institutional long term care. This NF bed demand will be based on the needs of specific populations for short and long term care, including:

- Persons recovering from acute episodes who require traditional nursing facility care, and need the continuous availability of care for the treatment of illness or injury, for a short term period.
- Persons recovering from acute episodes who require subacute care, and need the continuous availability of care that falls between acute care and longer-term nursing facility care, for a short term period.
- Persons who require institutional long term care, including frail elderly persons, persons with chronic conditions, persons with disabilities, persons with AIDS, and terminally ill persons, for an extended period.

### **1. The Demand for NF Beds for Institutional Long Term Care Projected to 2000, 2010, & 2020**

The future demand for NF beds for institutional long term care in San Francisco can be estimated by applying NF bed use rates to projected populations 65 and over. While older adults represent the vast majority requiring institutional care, states with comprehensive long term care systems note that the needs of younger persons are included in NF bed use rates. However, because managed care is increasing the use of institutional (subacute) care for the under 65 population, these demand projections may underestimate NF bed needs. Three different NF bed demand projection scenarios are provided based on: (1) Oregon's experience; (2) San Francisco's current situation; and (3) Washington's experience.

#### **The State of Oregon**

Oregon has a long term care service delivery program that emphasizes placement of elderly and disabled persons into home and community-based care. Major components of the program include: (1) developing supportive housing options such as congregate housing, adult foster care homes, and assisted living facilities; (2) establishing a certificate of need (CON) requirement for nursing facilities; (3) relocating elderly and disabled persons from nursing facilities; and (4) absorbing the increasing demand for long term care for elderly and disabled persons into its expanding home and community-based care programs. **Oregon currently has a NF bed use rate of 27 NF beds per 1,000 persons over the age of 65.**

## **The City of San Francisco**

There are now 3,625 NF beds in San Francisco which provide institutional long term care. This includes: (1) 1,214 NF beds at Laguna Honda Hospital; (2) 437 NF beds at the Jewish Home for the Aged; (3) 450 NF beds in acute care hospitals; (4) 120 NF beds in the VA Medical Centers nursing home; and (5) 1,404 NF beds in freestanding nursing facilities. The 1995 estimate by the State Department of Finance for persons 65 and over in San Francisco was 110,300 persons. The city's NF bed rate can be obtained by dividing the total 3,625 NF beds by a factor of 110.3 (the number of persons per 1,000 over the age of 65). **San Francisco currently has a NF bed use rate of 33 NF beds per 1,000 persons over age 65.**

## **The State of Washington**

Washington established a Medicaid waiver program in 1983 called Community Options Program Entry System (COPES) to provide additional community care options for elderly and disabled people who require long term care. In 1989, the state incorporated into its Certificate of Need (CON) statute a goal to reduce nursing home beds from 54 to 45 per 1,000 persons age 65 and over. **Washington currently has a NF bed use rate of 45 NF beds per 1,000 persons over age 65.**

### **Current NF Bed Use Rates for San Francisco, the State of Oregon, and the State of Washington**

- **The State of Oregon currently has a NF bed use rate of 27 NF beds per 1,000 persons over the age of 65.**
- **The City of San Francisco currently has a NF bed use rate of 33 NF beds per 1,000 persons over the age of 65.**
- **The State of Washington currently has a NF bed use rate of 45 NF beds per 1,000 persons over the age of 65.**

## **• Demand Projection Scenarios**

The following three scenarios project the demand for NF beds for institutional long term care in San Francisco between 1997 and 2020. The scenarios are based on the different experiences of the three geographic areas regarding the NF bed use rates reviewed above. These scenarios are helpful in predicting a range for the future demand for NF beds. The three scenarios are based on: (1) Oregon's experience, which provides the low end of the range; (2) San Francisco's current situation, which represents the middle of the range; and (3) Washington's experience, which provides the high end of the range.



## **SCENARIO 1: Projected demand for NF beds, based on San Francisco decreasing to 27 NF Beds per 1,000 persons over age 65 by 2020.**

### **Assumptions:**

- San Francisco will begin to develop additional home and community-based options for long term care between 1997 and 2000.
- An initial target goal for the NF bed use rate will remain at 33 NF beds per 1,000 persons over age 65 by 2000.
- An intermediate target goal for the NF bed use rate will be set at 30 NF beds per 1,000 persons over age 65 by 2010.
- A final target goal for the NF bed use rate will be set at 27 NF beds per 1,000 persons over age 65 by 2020.

1. Applying the initial target goal of 33 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2000 (116,080 persons), results in a **total estimated demand in 2000 for 3,831 NF beds.**
2. Applying the intermediate target goal of 30 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2010 (129,787 persons), results in a **total estimated demand in 2010 for 3,894 NF beds.**
3. Applying the final target goal of 27 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2020 (181,981 persons), results in a **total estimated demand in 2020 for 4,913 NF beds.**

## **SCENARIO 2: Projected demand for NF beds, based on San Francisco remaining at 33 NF Beds per 1,000 persons over age 65.**

### **Assumptions:**

- San Francisco will begin to develop some additional home and community-based options for long term care between 1997 and 2000, but only enough to maintain the current NF bed use rate.
- The NF bed use rate will remain at 33 NF beds per 1,000 persons over age 65 by 2000.
- The NF bed use rate will remain at 33 NF beds per 1,000 persons over age 65 by 2010.
- The NF bed use rate will remain at 33 NF beds per 1,000 persons over age 65 by 2020.

1. Applying the current NF bed use rate of 33 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2000 (116,080 persons), results in a **total estimated demand in 2000 for 3,831 NF beds.**
2. Applying the same NF bed use rate of 33 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2010 (129,787 persons), results in a **total estimated demand in 2010 for 4,282 NF beds.**
3. Applying the same NF bed use rate of 33 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2020 (181,981 persons), results in a **total estimated demand in 2020 for 6,005 NF beds.**

**SCENARIO 3: Projected demand for NF beds, based on San Francisco increasing to 45 NF Beds per 1,000 persons over age 65 by 2020.**

**Assumptions:**

- San Francisco will not begin to develop additional home and community-based options for long term care between 1997 and 2000. Instead, additional nursing facilities will be developed to address the increasing demand for long term care.
- An initial target goal for the NF bed use rate will remain at 33 NF beds per 1,000 persons over age 65 by 2000.
- An intermediate target goal for the NF bed use rate will be set at 37 NF beds per 1,000 persons over age 65 by 2010.
- A final target goal for the NF bed use rate will be set at 45 NF beds per 1,000 persons over age 65 by 2020.

1. Applying the initial target goal of 33 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2000 (116,080 persons), results in a **total estimated demand in 2000 for 3,831 NF beds.**
2. Applying the intermediate target goal of 37 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2010 (129,787 persons), results in a **total estimated demand in 2010 for 4,802 NF beds.**
3. Applying the final target goal of 45 NF beds per 1,000 persons over age 65 to San Francisco's projected population 65 and over for 2020 (181,981 persons), results in a **total estimated demand in 2020 for 8,189 NF beds.**

The following table summarizes the three different scenarios demonstrating NF bed demand for San Francisco, for institutional long term care projected to 2000, 2010, and 2020.

### **Demand for NF Beds Projected to 2000, 2010, & 2020**

	2000	2010	2020
<b><u>Scenario 1</u></b> (based on Oregon's experience)	<b>3,831</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>3,894</b> <b>NF Beds</b> (30 NF beds per 1,000 persons over 65)	<b>4,913</b> <b>NF Beds</b> (27 NF beds per 1,000 persons over 65)
<b><u>Scenario 2</u></b> (based on San Francisco's current situation)	<b>3,831</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>4,282</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>6,005</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)
<b><u>Scenario 3</u></b> (based on Washington's experience)	<b>3,831</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>4,802</b> <b>NF Beds</b> (37 NF beds per 1,000 persons over 65)	<b>8,189</b> <b>NF Beds</b> (45 NF beds per 1,000 persons over 65)

## **2. The Demand and Supply of NF Beds Projected to 2000, 2010, & 2020**

The demand and the supply of NF beds can be projected to 2000, 2010 and 2020. These projections are applied to the three scenarios presented above. The remaining deficit of NF beds is related to the different NF bed use rates employed to establish each scenario.

The projections assume that Laguna Honda Hospital (LHH) would be maintained until sometime after 2000. For purposes of this Study only, it is also assumed that Laguna Honda Hospital could be replaced by a smaller long term care facility of 600 beds by 2010. This new facility would be targeted for the most medically complex Medi-Cal and medically indigent adult patients, for whom home and community-based care is not an option.

The projections also assume that the equivalent of one 350 bed acute care hospital could be converted to a long term care facility between 2001 and 2010, and that the equivalent of a second 350 bed acute care hospital could be converted to a long term care facility between 2011 and 2020.



## Period One: 1997 to 2000

**Summary of elderly population growth in this period.** By 2000, the number of persons 65 and over is projected to increase by 10,700, from 105,380 persons in 1990 to 116,080 persons. There will also be a projected increase of 5,570 persons over the age of 85, from 12,148 persons in 1990 to 17,148 persons in 2000.

### **Assumptions:**

- The projected demand for NF beds for all three scenarios will be 3,831 NF beds (based on 33 NF beds per 1,000 persons over age 65).
- Laguna Honda Hospital (LHH) would be maintained at its existing capacity with 1,214 NF beds until sometime after 2000.
- The Jewish Home for the Aged would be maintained at 437 NF beds.
- Existing hospital-based nursing facilities would be maintained at 450 NF beds.
- Existing freestanding nursing facilities would be maintained at 1,404 NF beds.
- The VA Medical Center nursing facility would be maintained at 120 NF beds.

### Projected Demand and Supply of NF Beds from 1997 to 2000

	Scenario 1	Scenario 2	Scenario 3
<b>Projected Demand for NF Beds:</b>	<b>3,831</b> (33 NF beds per 1,000 persons over 65)	<b>3,831</b> (33 NF beds per 1,000 persons over 65)	<b>3,831</b> (33 NF beds per 1,000 persons over 65)
<b>Projected Supply of NF Beds:</b>			
• Maintain existing Laguna Honda Hospital	- 1,214	- 1,214	- 1,214
• Maintain the Jewish Home for the Aged	- 437	- 437	- 437
• Maintain Hospital-Based Nursing Facilities	- 450	- 450	- 450
• Maintain Freestanding Nursing Facilities	- 1,404	- 1,404	- 1,404
• Maintain VA Nursing Home	- 120	- 120	- 120
<b>Subtotal</b>	<b>3,625</b>	<b>3,625</b>	<b>3,625</b>
<b>Difference</b>	<b>206</b>	<b>206</b>	<b>206</b>
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	<b>- 271</b>	<b>- 271</b>	<b>- 271</b>
<b>Deficit of NF Beds</b>	<b>0</b>	<b>0</b>	<b>0</b>

## Period Two: 2001 to 2010

**Summary of elderly population growth in this period.** By 2010, the number of persons 65 and over is projected to increase by 13,707, from 116,080 persons in 2000 to 129,787 persons. There will also be a projected increase of 6,240 persons over the age of 85, from 17,718 persons in 2000 to 23,958 persons in 2010.

### **Assumptions:**

- Under Scenario 1, the projected demand will be for 3,894 NF beds (30 NF beds per 1,000 persons over age 65). Under Scenario 2, the projected demand will be for 4,282 NF beds (33 NF beds per 1,000 persons over age 65). Under Scenario 3, the projected demand will be for 4,802 NF beds (37 NF beds per 1,000 persons over age 65).
- Laguna Honda Hospital would be replaced with a new, smaller long term care facility of approximately 600 NF beds.
- The Jewish Home for the Aged would be maintained at 437 NF beds.
- Existing hospital-based nursing facilities would be maintained at 450 NF beds.
- Existing freestanding nursing facilities would be maintained at 1,404 NF beds.
- The VA Medical Center nursing facility would be maintained at 120 NF beds.
- The equivalent of one acute care hospital of approximately 350 beds could be converted to a long term care facility. (NOTE: It may be desirable to have a scaled-back acute care hospital, which is primarily a distinct part nursing facility, that also provides access to the community for ambulatory care services, emergency services, and a small number of acute beds focused on the acute needs of a large long term care population.)

### Projected Demand and Supply of NF Beds from 2001 to 2010

	Scenario 1	Scenario 2	Scenario 3
<b>Projected Demand for NF Beds:</b>	<b>3,894</b> (30 NF beds per 1,000 persons over 65)	<b>4,282</b> (33 NF beds per 1,000 persons over 65)	<b>4,802</b> (37 NF beds per 1,000 persons over 65)
<b>Projected Supply of NF Beds:</b>			
• Develop a new Laguna Honda Hospital	- 600	- 600	- 600
• Maintain the Jewish Home for the Aged	- 437	- 437	- 437
• Maintain Hospital-Based Nursing Facilities	- 450	- 450	- 450
• Maintain Freestanding Nursing Facilities	- 1,404	- 1,404	- 1,404
• Maintain VA Nursing Home	- 120	- 120	- 120
• Convert one Hospital to a LTC Facility	- 350	- 350	- 350
<b>Subtotal</b>	<b>3,361</b>	<b>3,361</b>	<b>3,361</b>
<b>Difference</b>	<b>533</b>	<b>921</b>	<b>1,441</b>
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	- 271	- 271	- 271
<b>Deficit of NF Beds</b>	<b>262</b>	<b>650</b>	<b>1,170</b>

## Period Three: 2011 to 2020

**Summary of elderly population growth in this period.** By 2020, the number of persons 65 and over is projected to increase by 52,194, from 129,787 persons in 2010 to 181,981 persons. There will also be a projected increase of 2,874 persons over the age of 85, from the 23,958 persons in 2010 to 26,832 persons in 2020.

### **Assumptions:**

- Under Scenario 1, the projected demand will be for 4,913 NF beds (27 NF beds per 1,000 persons over age 65). Under Scenario 2, the projected demand will be for 6,005 NF beds (33 NF beds per 1,000 persons over age 65). Under Scenario 3, the projected demand will be for 8,189 NF beds (45 NF beds per 1,000 persons over age 65).
- The new Laguna Honda Hospital would be maintained at 600 NF beds.
- The Jewish Home for the Aged would be maintained at 437 NF beds.
- Existing hospital-based nursing facilities would be maintained at 450 NF beds.
- Existing freestanding nursing facilities would be maintained at 1,404 NF beds.
- The VA Medical Center nursing facility would be maintained at 120 NF beds.
- The new long term care (LTC) facility would be maintained at 350 NF beds.
- The equivalent of a second acute care hospital of approximately 350 beds could be converted to a long term care facility.

### **Projected Demand and Supply of NF Beds from 2011 to 2020**

	Scenario 1	Scenario 2	Scenario 3
<b>Projected Demand for NF Beds:</b>	<b>4,913</b> (27 NF beds per 1,000 persons over 65)	<b>6,005</b> (33 NF beds per 1,000 persons over 65)	<b>8,189</b> (45 NF beds per 1,000 persons over 65)
<b>Projected Supply of NF Beds:</b>			
• Maintain new Laguna Honda Hospital	- 600	- 600	- 600
• Maintain the Jewish Home for the Aged	- 437	- 437	- 437
• Maintain Hospital-Based Nursing Facilities	- 450	- 450	- 450
• Maintain Freestanding Nursing Facilities	- 1,404	- 1,404	- 1,404
• Maintain VA Nursing Home	- 120	- 120	- 120
• Maintain new LTC Facility	- 350	- 350	- 350
• Convert 2nd Hospital to a LTC Facility	- 350	- 350	- 350
<b>Subtotal</b>	<b>3,711</b>	<b>3,711</b>	<b>3,711</b>
<b>Difference</b>	<b>1,202</b>	<b>2,294</b>	<b>4,478</b>
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	<b>- 271</b>	<b>- 271</b>	<b>- 271</b>
<b>Deficit of NF Beds</b>	<b>931</b>	<b>2,023</b>	<b>4,207</b>



### **3. Future NF Bed Demand and Supply Summary**

Following is a summary of the demand and the supply of NF beds in San Francisco, projected to 2000, 2010 and 2020. The remaining deficit of NF beds is related to the different NF bed use rates employed to establish the projected demand.

#### **Future NF Bed Demand and Supply Summary**

	<b>2000</b>	<b>2010</b>	<b>2020</b>
<b>Projected Demand for NF Beds</b>	3,831	3,894 - 4,802	4,913 - 8,189
<b>Projected Supply of NF Beds</b>	3,625	3,361	3,711
<b>Difference</b>	206	533 - 1,441	1,202 - 4,478
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	- 271	- 271	- 271
<b>Deficit of NF Beds</b>	0	262 - 1,170	931 - 4,207

## **Section 5.**

### **Issues Related to the Future Demand and Supply of Nursing Facility (NF) Beds**

## **Section 5. Issues Related to the Future Demand and Supply of Nursing Facility (NF) Beds**

Many issues will influence the future number of acute beds available to address the demand for institutional long term care in San Francisco. One of these is the health care market, which will affect the demand for acute beds and for NF beds in a variety of ways. The heightened competition of the health care industry will have several consequences for the future of acute care services, and for the potential availability of acute beds for other kinds of services - such as skilled nursing care provided in hospital-based NF beds. Some consequences could be beneficial and others could be negative, depending upon each hospital's position in the marketplace.

This section presents the potential impact of managed care on: (1) the demand for acute beds, (2) the demand for NF beds and subacute beds, and (3) the availability of NF beds for institutional long term care. This section also presents observations based on hospital interviews and the research undertaken for this Nursing Facility Bed Study.

### **1. Potential Impact of Managed Care on Demand for Acute Beds**

As a result of greater managed care penetration, health care experts anticipate that San Francisco's hospitals may experience: (1) a reduced number of inpatient admissions; (2) a reduced average length of stay; and (3) a reduced demand for acute beds. Projections of demand for acute beds by 2000 range from 750 to 1,000 beds for city residents, with an additional 250 beds needed for other patients referred to hospitals for specialized services. In June 1996, the average length of stay in available acute hospital beds was as follows:

**Average Length of Stay in Acute Care Hospital Beds, June 1996**

<b>Hospital Name</b>	<b>Available Acute Bed Capacity</b>	<b>Acute Bed Average Daily Census</b>	<b>Acute Bed Average Length of Stay</b>
Chinese Hospital	59	36	5.20 days
California Pacific Medical Center	337	228	4.30 days*
Kaiser Medical Center	226	151	4.20 days
Davies Medical Center	272	44	5.58 days
San Francisco General Hospital	338	270	5.80 days
Saint Francis Memorial Hospital	191	82	4.80 days
St. Luke's Hospital	101	70	5.10 days
St. Mary's Medical Center	448	173	5.60 days
UCSF Medical Center /Mount Zion	784	441	5.80 days
VA Medical Center	244	155	5.30 days
Pacific Coast Hospital	28	1	1.00 days
Seton Medical Center	209	132	5.58 days
<b>TOTALS</b>	<b>3,237</b>	<b>1,783</b>	

\*CPMC's average length of stay is low due to obstetrics and high end tertiary care.



The average length of stay in San Francisco hospitals can be compared with hospitals in another geographic area where managed care has reached a higher degree of market penetration. San Diego has a high degree of managed care penetration (53.8% in 1994) that has impacted the average length of stay in acute hospital beds. A sampling of three hospitals operated by Sharp Health Care, one provider network in San Diego, indicates the average length of stay as of June 1996 for approximately 700 acute care patients ranged between 4.40 and 4.66 days. The difference between the average length of stay in San Francisco hospitals and those sampled in San Diego is approximately 1.0 to 1.25 days.

Demand for acute beds. Demand for acute beds is based on an estimated number of patient days per 1,000 persons per year, tied to age. Estimated acute bed use rates applied to a population produces estimated patient days. Acute beds required result from dividing the estimated patient days by 365, and planning for 80% occupancy by multiplying that number by 1.20%:

**Population/1,000 X Acute Bed Use Rate = Patient Days.**

**Patient Days/365 X 1.20% = Acute Beds Required.**

A report by the New Century Healthcare Institute, entitled Bay Area Hospital Stock under Managed Care Scenarios, dated January 1994, states that "currently, the most aggressive capitated group practices in California target a use rate of under 200 patient days/1,000" (for under 65). The Institute's report also states that "the experience of Medicare HMOs, still less than 3% of the managed care market in Northern California, is that the use rate is half of the normal Medicare use rate of over 2,000 patient days/1,000" (for 65 and over).

However, the HCFA Office of Research and Demonstrations has found that Medicare managed care beneficiaries use 88% of services as compared with fee-for-service beneficiaries. Accordingly, using only the bed use rates of more advanced managed care providers may provide unrealistically low projections as a basis for acute bed demand.

To project demand for Bay Area acute beds in 2005, the Institute report employs bed use rates based on the experience of more advanced managed care providers: (1) 130 patient days per 1,000 persons under 65; and (2) 950 patient days per 1,000 persons 65 and over.

Applying the Institute's acute bed use rates to San Francisco's projected populations under 65 years of age and 65 and over for the year 2000, and planning for 80% occupancy, results in a total estimated acute care bed demand for **644 beds**. Acute care bed use rates based on a somewhat less advanced managed care environment would result in a higher number of acute care beds needed for San Francisco in the year 2000. For example, acute care bed use rates of: (1) 230 patient days per 1,000 persons under 65; and (2) 1,350 patient days per 1,000 persons 65 and over, and planning for 80% occupancy, would result in a total estimated acute care bed demand in the year 2000 for **1,013 beds**.

Applying the Institute's acute bed use rates to San Francisco's projected populations under 65 years of age and 65 and over for 2010, and planning for 80% occupancy, results in a total estimated acute care bed demand for **684 beds**. Again, acute care bed use rates based

on a somewhat less advanced managed care environment would result in a higher number of acute care beds needed for San Francisco in the year 2010. As before, acute care bed use rates of: (1) 230 patient days per 1,000 persons under 65; and (2) 1,350 patient days per 1,000 persons 65 and over, and planning for 80% occupancy, would result in a total estimated acute care bed demand in the year 2010 for **1,069 beds**.

## **2. Potential Impact of Managed Care on the Demand for NF Beds and Subacute Beds**

As hospitals decrease acute care admissions due to managed care, and as the average length of stay in acute beds decreases, hospitals may respond by: (1) discharging patients earlier from acute care beds and placing some patients in nursing facilities; and (2) developing distinct part, PPS-exempt subacute units, to provide subacute care for Medicare patients and to increase the capacity to care for more acutely ill post-acute patients.

As of June 1996, the acute average daily census in San Francisco hospitals was 1,783 beds. The difference between this and the projected need for 1,000 acute beds under greater managed care penetration represents 783 patients. Should the cumulative acute average daily census drop to 1,000 beds, some of the 783 patients previously cared for in acute beds would generate a post-acute care bed demand. While some of this demand could be addressed by nursing facilities, a portion of it could be addressed by subacute facilities.

Should the average length of stay in acute beds continue to drop to between 4.4 and 4.6 days in San Francisco, some of the patients no longer cared for in acute beds may generate a demand for post-acute care. Again, while some of this demand could be addressed by traditional nursing facilities, a portion of this demand could be addressed by the development of subacute care facilities.

## **3. Potential Impact of Managed Care on the Availability of NF Beds for Institutional Long Term Care**

All of San Francisco's hospitals will continue to determine how they best fit into the changing market for health care services. The highly competitive managed care environment will require each hospital to be concerned about operating efficiency, and to compete for admissions to better utilize assets and to hold down costs. The pending or completed mergers, the formation of regional health care delivery systems, and the strategic plans being developed indicate each hospital's best effort to place itself in the most favorable position within this new marketplace. However, if a strategy is unsuccessful in effectively aligning a hospital to the new competitive environment, then that strategy may have to change or the hospital's ability to survive may be at risk.

In June 1996, San Francisco's total acute bed capacity was 3,237 acute beds. Should the cumulative acute average daily census in San Francisco hospitals drop from the June 1996 figure of 1,783 beds to 1,000 beds by the year 2000 due to managed care, additional acute beds may be available to address the increasing demand for long term care.



#### **4. Observations**

##### **Hospital Interviews:**

1. Hospitals expressed interest in converting acute beds to NF beds to address the demand for long term care. Several hospitals expressed interest in exploring opportunities to develop additional NF beds in their institutions, but were concerned about:

- financial incentives for capital costs associated with the conversion of acute units to nursing facility units.
- adequate reimbursement to cover the cost of heavy care patients.
- referrals of patients.
- sharing risk for the provision of institutional long term care.
- regulatory requirements and licensing issues related to conversion.

2. Some hospitals expressed an interest in relationships to provide additional NF beds. Proposals include:

- leasing space within their institution.
- shared ownership.
- joint subsidy of conversion.

3. Some hospitals, which provide limited or no nursing facility services, expressed interest in opportunities to refer patients to other facilities that may have additional NF bed capacity. Proposals include:

- leasing excess NF bed capacity in other institutions for post-acute or long term care.
- joint ventures with other institutions to develop additional NF bed capacity.

##### **Period One: 1997-2000**

1. Opportunities could be explored with hospitals that have expressed interest in possibly developing additional NF beds in their institutions, and in developing relationships with other institutions for the use of such additional NF beds, to provide long term care.

2. Opportunities could also be explored with hospitals that have expressed interest in obtaining NF beds in other institutions to meet their own demand for long term care.

3. A NF bed task force could be formed to investigate these opportunities which would include representatives of DPH and all hospitals interested in NF bed availability.



4. The Department of Public Health (DPH), which will always have a safety net function in long term care, could begin to investigate the feasibility of replacing the existing Laguna Honda Hospital (LHH) with a smaller long term care facility of approximately 600 NF beds.
5. As part of a transition plan for the future placement of some LHH patients, DPH could begin to explore the potential of converting acute beds to NF beds in hospitals. This could include: (1) referral relationships; (2) leasing of space; (3) shared ownership; (4) joint subsidy of conversion; (5) financial incentives for capital costs; (6) the adequacy of reimbursement for heavy care patients; and (7) working collaboratively with the State Department of Health Services on regulatory requirements and licensing issues related to conversion.
6. Additional alternatives for long term care for the elderly and the disabled could be developed, creating an increased capacity for nursing facility eligible persons in home and community-based settings to meet a portion of the remaining NF bed deficit.
7. Supportive housing, such as assisted living facilities, congregate housing, and adult foster care homes could be explored as new options for those who need residential settings in which long term care services can be provided.
8. Most of the growth in the population needing long term care could be absorbed into home and community-based alternatives.

### **Period Two: 2001-2010**

1. Opportunities could continue to be explored with hospitals that have expressed interest in developing relationships with other institutions for the use of additional NF beds.
2. Relationships could be developed with one or more hospitals to: (1) use acute beds currently "in suspense"; or (2) convert beds in unused acute units to NF units in order to meet a portion of the remaining NF bed deficit.
3. Placement plans could be developed to provide for the continuation of care for those patients no longer to be cared for at the new Laguna Honda Hospital. Such plans could involve both institutional nursing facility options for heavy care patients, and home and community-based options for lighter care patients.
4. Home and community-based alternatives for long term care for the elderly and the disabled could continue to be developed, creating increased capacity for nursing facility eligible persons in home and community-based settings, to meet a portion of the remaining NF bed deficit.
5. Supportive housing options such as assisted living facilities, congregate housing, and adult foster care homes could continue to be developed for those who need residential settings in which long term care services can be provided.
6. Most of the growth in the population needing long term care services could be absorbed into home and community-based alternatives.

### **Period Three: 2011-2020**

1. Opportunities could continue to be explored with hospitals that have expressed interest in developing relationships with other institutions for the use of additional NF beds.
2. Relationships could be developed with additional hospitals to: (1) use acute beds currently “in suspense”; or (2) convert beds in unused acute units to NF units in order to meet a portion of the remaining NF bed deficit.
3. Because of the dramatic increase in persons 65 and over, and due to the continuing growth in the number of persons 85 and over who will require care during this period, services could be increased as needed so many individuals could age in place, and remain in home and community-based settings.
4. Home and community-based alternatives for long term care for the elderly and the disabled could continue to be developed, creating increased capacity for nursing facility eligible persons in home and community-based settings to meet a portion of the remaining NF bed deficit.
5. Supportive housing options such as assisted living facilities, congregate housing, and adult foster care homes could continue to be developed for those who need residential settings in which long term care services can be provided.
6. Most of the growth in the population needing long term care services could be absorbed into home and community-based alternatives.





## **Section 6.**

### **Seismic Safety Standards for California Hospitals**

## **Section 6. Seismic Safety Standards for California Hospitals**

This section explores the new seismic safety standards for acute hospital buildings in California. Because some of San Francisco's hospitals may potentially provide additional NF beds to address a portion of the demand for long term care, it is necessary to be aware of these new standards and the existing conditions of acute hospital buildings.

The Alquist Hospital Facilities Seismic Safety Act of 1983 establishes standards for hospital buildings constructed on or after March 7, 1973. Such hospital buildings are subject to the Office of Statewide Health Planning and Development's (OSHDP) seismic standards in Title 24 of the California Administrative Code. Hospital buildings constructed before this date are not subject to these standards.

### **1. New Seismic Safety Standards for Hospital Buildings**

Following the Northridge earthquake in 1992, the State legislature adopted SB 1953 (Alquist) to establish seismic safety standards for all California hospitals not in compliance with current seismic requirements. This legislation targeted hospital buildings constructed before 1973. It requires OSHPD to develop seismic safety standards for hospital buildings constructed prior to March 7, 1973. OSHPD must develop and adopt these new seismic safety standards for both structural and non-structural (e.g., supply of emergency fuel) attributes of a facility. New seismic safety standards will be issued by July 1, 1997.

Once new seismic safety standards are issued, owners of acute care hospital buildings must, within three years (by July 1, 2000), conduct seismic evaluations. If acute care hospital buildings built before March 7, 1973 do not comply with these standards, owners must prepare comprehensive plans and compliance schedules. Acute care hospital buildings posing a significant risk and danger to the public must comply with the structural standards by January 1, 2008, or be removed from acute care services and used only for nonacute care and administrative purposes. All hospital buildings must comply with the structural standards by January 30, 2030.

OSHDP is also required to review seismic evaluations of individual hospitals, negotiate compliance schedules for those hospitals that do not meet the new standards, and monitor their progress toward achieving compliance. SB 1953 will have a significant effect on California hospitals.

In response to SB 1953, to facilitate the evaluation of existing buildings, OSHPD has developed a **Seismic Evaluation Procedure for Hospital Buildings**. This Procedure is based on a FEMA 178 evaluation procedure as much as possible, but modified to provide general criteria suitable specifically for hospitals. Some of the most important components of the Seismic Evaluation Procedure are: (1) the structural performance categories (SPC); and (2) the nonstructural performance categories (NPC). After seismic evaluations are completed, these are the categories into which acute care hospital buildings will be placed.

### Structural Performance Categories (SPC)

SPC	Description
SPC 1	Buildings posing a significant risk of collapse and danger to the public. These buildings must be brought up to the Structural Performance Category (SPC) 2 level by January 1, 2008 or be removed from acute care service.
SPC 2	Buildings in substantial compliance with the pre-1973 California Building Standards Code, but not in substantial compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act. These buildings do not significantly jeopardize life, but may not be repairable or functional following strong ground motion. These buildings must be into compliance with the structural provisions of the Alquist Hospital Seismic Safety Act, its regulations, or its retrofit provisions by January 1, 2030 or be removed from acute care service.
SPC 3	Buildings in compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, utilizing steel moment resisting frames in regions of high seismicity as defined in Section 4.2.10 and constructed under a permit issued prior to October 25, 1994. These buildings may experience structural damage which does not significantly jeopardize life, but may not be repairable or functional following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD.
SPC 4	Buildings in full compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, but may experience structural damage which may inhibit ability to provide services to the public following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used to January 1, 2030 and beyond.
SPC 5	Buildings in full compliance with the structural provisions of the Alquist Hospital Facilities Seismic Safety Act, and reasonably capable of providing services to the public following strong ground motion. Buildings in this category will have been constructed or reconstructed under a building permit obtained through OSHPD. These buildings may be used without restriction to January 1, 2030 and beyond.



All hospital buildings designed and constructed after March 7, 1973. If hospital buildings were designed and constructed after March 7, 1973, these buildings were built in full compliance with Title 24 of the California Administrative Code, as it was written at that time. As a result, they will automatically fall into SPC Levels 3, 4, or 5. **Level 3, 4, and 5 hospital buildings will be reasonably capable of providing services to the public following an earthquake, or may experience structural damage which should not significantly jeopardize life.** These hospital buildings will have no requirements to do any additional strengthening.

Steel frame hospital buildings designed and constructed before October 25, 1994.

However, due to the poor performance of steel frame hospital buildings in the Northridge earthquake, drastic changes were made to Title 24 of the California Administrative Code in 1994. These changes disallowed a style of connection between building girders and columns which demonstrated considerable stress and structural damage during the earthquake. The revised Code states that this type of connection can no longer be used in steel frame hospital buildings. As a result, all steel frame hospital buildings designed and constructed before October 25, 1994 will fall into SPC Level 3. **Level 3 hospital buildings may experience structural damage during or after an earthquake, but should not significantly jeopardize life.** As with buildings in SPC Level 4 and 5, hospital buildings in Level 3 will have no requirements to do any additional strengthening.

All hospital buildings designed and constructed before March 7, 1973. All hospital buildings designed and constructed before March 7, 1973 will fall in SPC levels 1 or 2.

- **SPC Level 2 hospital buildings may suffer damage during an earthquake, but they should not collapse. However, while these buildings should not significantly jeopardize life, they may not be repairable or functional following strong ground motion. As a result, these buildings have until January 1, 2030 to be strengthened, and brought into substantial compliance with the provisions of the Alquist Hospital Seismic Safety Act, or be removed from acute care service.**

- **SPC Level 1 hospital buildings may collapse during or after an earthquake, and pose a significant risk and danger to the public. These buildings must be strengthened, and brought up to SPC Level 2 by January 1, 2008, or be removed from acute care service. If owners of general acute care hospitals have dangerous buildings, they must be seismically upgraded to continue to provide acute care.**

Evaluation criteria for acute care hospital buildings were approved by the Building Standards Commission on March 18, 1997. Seismic retrofit regulations and administrative regulations for the seismic retrofitting of acute care hospital buildings were submitted to the Building Standards Commission on December 31, 1996. These regulations will undergo a public review process and will be finally adopted on or before July 1, 1997.

Exemption for hospital buildings which do not provide acute care. Unless a hospital has 10% or more of the beds licensed for acute care, it is exempt from SB 1953 requirements.

### Nonstructural Performance Categories

Timeframes	Nonstructural Performance Category	Description
	NPC 1	Buildings with equipment and systems not meeting the bracing and anchorage requirements of any other NPC.
January 1, 2002	NPC 2	<p>The following systems are braced or anchored in accordance with Part 2, Title 24:</p> <ul style="list-style-type: none"> <li>■ communications systems;</li> <li>■ emergency power system;</li> <li>■ bulk medical gas systems; and</li> <li>■ fire alarm systems.</li> </ul>
January 1, 2005	NPC 3	<p>The building meets the criteria for NPC "2" and in Critical Care Areas, the following components meet the bracing and anchorage requirements of Part 2, Title 24:</p> <ul style="list-style-type: none"> <li>■ Nonstructural components, as listed in Part 2, Title 24, Table 16A-O, "Nonstructural components", Items 4 and 5;</li> <li>■ Tanks and vessels (including contents), mechanical and electrical equipment, where an anchorage failure of these items will endanger function in the Critical Care Areas.</li> </ul>
January 1, 2008	NPC 4	<p>The building meets the criteria for NPC "3" and in Critical Care Areas, clinical laboratory service spaces, pharmaceutical service spaces, radiological service spaces, and central and sterile supply areas, the following components meet the bracing and anchorage requirements of Part 2, Title 24:</p> <ul style="list-style-type: none"> <li>■ Nonstructural components, as defined in Part 2, Title 24, Table 16A-O, "Nonstructural components", and</li> <li>■ Equipment, as defined in Part 2, Title 24, Table 16A-O, "Equipment" including equipment in the physical plant that service these areas.</li> </ul> <p><i>Exceptions:</i></p> <ol style="list-style-type: none"> <li>1. Seismic restraints need not be provided for cable trays, conduit and HVAC ducting. Seismic restraints may be omitted from piping systems, provided that an approved method of preventing release of the contents of the piping system in the event of a break is provided.</li> <li>2. Only elevator(s) selected to provide service to patient, surgical, obstetrical, and ground floors during interruption of normal power need meet the structural requirements of Part 2, Title 24.</li> </ol> <ul style="list-style-type: none"> <li>■ Fire sprinkler systems comply with the bracing and anchorage requirements of NFPA 13, 1994 edition or subsequent applicable standards.</li> </ul>
	NPC 5	The building meets the criteria for NPC "4" and all architectural, mechanical, electrical systems, components and equipment, and hospital equipment meet the bracing and anchorage requirements of Part 2, Title 24. This category is for classification purposes of the Office of Emergency Services.
January 1, 2030	NPC 6	The building meets the criteria for NPC "5" and on-site supplies of water and holding tanks for wastewater, sufficient for 72 hours emergency operations, are integrated in to the building plumbing systems. As an alternative, hook-ups to allow for the use of transportable sources of water and sanitary waste water disposal have been provided. An on-site emergency system as defined within Part 3, Title 24 is incorporated into the building electrical system for critical care areas. This shall include task lighting, selected outlets and ventilation systems. Additionally, the system shall provide for radiological service and an onsite fuel supply for 72 hours of acute care operation.



Earthquake performance category (EPC). The earthquake performance category (EPC) is rating for each hospital building. This is a measure of the expected performance of the building in an earthquake, expressed as a combination of the SPC and NPC, in the form of "SPC/NPC". For example, an overall rating for a building could be SPC-3/NPC-4.

## **2. Hospital Buildings that may be Converted to Nursing Facility Services**

Following a seismic evaluation, a hospital may decide to convert an SPC Level 1 or 2 hospital building from acute care to nonacute uses, including nursing facility services. Should this occur, OSHPD would determine structural and seismic requirements based on the number of stories in the building. If a single story structure, the building would have to comply with the Uniform Building Code (UBC). If a multi-story structure, the building would have to comply with Title 24 of the California Administrative Code.

**Attention needs to be given to leasing or converting acute care units to nursing facility services. Hospital buildings placed in Structural Performance Category (SPC) Level 1 may collapse during or after an earthquake, posing a significant risk and danger to the public. Hospital buildings placed in SPC Level 2 may suffer damage during an earthquake, but they should not collapse or significantly jeopardize life. In addition, hospital buildings designated as SPC Levels 3, 4 and 5 may also be considered for conversion to nursing facility care. These hospital buildings should not collapse or significantly jeopardize life.**

Individual Hospital Profiles. Individual Hospital Profiles in regard to seismic safety standards, and existing conditions of acute hospital buildings, can be found in Appendix C.



## AFTERWORD

Bill Haskell has over 11 years of experience in health care in the San Francisco Bay Area. This includes: long term care services planning for older adults and persons with AIDS, health care program development, health care program administration, and long term care/hospice facility planning and development. He has worked extensively with: (1) Visiting Nurses and Hospice of San Francisco, (2) California Pacific Medical Center, and (3) the San Francisco Department of Public Health.

Since 1995, Mr. Haskell has been working as a private consultant, providing health care planning and program development services. He has worked primarily in the areas of long term care planning and HIV service delivery. Mr. Haskell's clients have included: (1) the San Francisco Commission on the Aging, for the development of a comprehensive long term care case management plan; (2) AIDS Housing of Washington, for research into financing HIV long term care services; (3) the AIDS Health Project of San Francisco, for HIV program development services; (4) Alameda County Housing and Community Development, for the development of an HIV long term care facility plan for Alameda and Contra Costa Counties; (5) the Hospital Council of Northern and Central California, for the San Francisco Nursing Facility Bed Study; and (6) the San Francisco Adult Day Health Network, for the development of a strategic plan.

From April 1995 until December 1996, Mr. Haskell also facilitated San Francisco's Ad Hoc Long Term Care Planning Committee. The goals of this Committee were: (1) to develop a comprehensive system of long term care services, which will provide access to a variety of health, medical, and social services for all San Franciscans who require long term care; and (2) to prepare San Francisco to participate in the State of California's long term care integration pilot project, which will test strategies for integrating long term care services and for achieving an array of services that promotes efficiency and maximizes resources.

From 1989 to 1995, Mr. Haskell was employed by the San Francisco Department of Public Health (DPH). He investigated the potential of converting the U.S. Public Health Services Hospital, located in the Presidio, into an AIDS long term care facility. Subsequently, he administered over \$40,000,000 annually in Ryan White CARE funds for HIV health care services for the DPH AIDS Office. He was specifically responsible for long term care planning, and for the development of housing and hospice programs.

From 1985 to 1988, Mr. Haskell managed the development of Coming Home Hospice, the first residential hospice facility in the United States for persons with AIDS and other terminal illnesses. To assist health care organizations throughout the United States in developing hospice facilities for persons with AIDS, in 1987 he co-authored a book, *Developing AIDS Residential Settings*, funded by the Robert Wood Johnson Foundation.

## FOOTNOTES for Section 1 through Section 6:

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- <sup>1</sup> AARP, Public Policy Institute, *Long Term Care Fact Sheet*, .FS 27R, 1995.
- <sup>2</sup> AARP, Public Policy Institute, *Nursing Homes Fact Sheet*, .APFS10R, 1995.
- <sup>3</sup> AARP, Public Policy Institute, *Long Term Care Fact Sheet*, .FS 27R, 1995.
- <sup>4</sup> AARP, Public Policy Institute, *New Directions for State Long Term Care Systems*, .AP9602, pp1,2, 1996.
- <sup>5</sup> Oregon's Long Term Care System, *From Nursing Facility Care to Community-Based Care: An Evolution*. Oregon Department of Health and Human Services, 1996.
- <sup>6</sup> AARP, Public Policy Institute, *New Directions for State Long Term Care Systems*, .AP9602, pp14 to 15, 1996.
- <sup>7</sup> Lewin VHI, for the Department of Health and Human Services, *Subacute Care: Policy Synthesis and Market Area Analysis*, 1995, ES 1.
- <sup>8</sup> Lewin VHI, for the Department of Health and Human Services, *Subacute Care: Policy Synthesis and Market Area Analysis*, 1995, pp 2.1 to 2.2.
- <sup>9</sup> Journal of Nursing, *Reduced Length of Stay in Stepdown Units for First Day Heart Surgery Patients*, December 1995.
- <sup>10</sup> U.S. Bureau of the Census, *65+ in the United States*, Washington, D.C., pp 2-2, 1996.
- <sup>11</sup> General Accounting Office, *Long Term Care, Projected Needs of the Aging Baby Boom Generation*, Washington, D.C., p. 21, 1991.
- <sup>12</sup> Vladeck, Bruce, Nancy Miller and Steven Clauser, *The Changing Face of Long Term Care*, Health Care Financing Review, 14, no. 4 (summer 1993), pp.5 to 23.
- <sup>13</sup> Van Nordstrand, J.F.S.E. Funer, and R. Suzman, eds. *Health Data on Older Americans: United States, 1992*. National Center for Health Statistics, Vital Health Statistics 3, no. 27, DHS Publication 93-1411.
- <sup>14</sup> Agency for Health Care Policy and Research, *National Bill for Diseases Treated in U.S. Hospitals*, Research Note no. 19, February 1994.
- <sup>15</sup> Densen, Paul M., *Tracing the Elderly Through the Health Care System*. ACHPR Monograph, 1991.







**SAN FRANCISCO  
NURSING FACILITY BED STUDY**

**Comprehensive Report Summary**

**The San Francisco Section  
of the West Bay Hospital Conference**

Hospital Council of Northern and Central California

**May 1997**

CHAPTER 1

THE HISTORY OF THE UNITED STATES

THE HISTORY OF THE UNITED STATES

CHAPTER 2

THE HISTORY OF THE UNITED STATES

THE HISTORY OF THE UNITED STATES

CHAPTER 3



# Comprehensive Report Summary

## 1. Statement of Purpose

San Francisco has a large and growing elderly population, many of whom will require long term care. While the numbers of elderly persons 65 and over is constantly increasing, the substantial growth in the elderly population will occur from 2010 to 2020. Hopefully, the relatively low rate of growth in this population over the next several years will provide an opportunity to plan for the rapid growth which will begin to occur after 2010. Increasing numbers of disabled and chronically ill persons will also require long term care.

This Nursing Facility Bed Study was initiated to investigate the relationship between the future supply and demand for nursing facility (NF) beds. Its purpose is to: (1) analyze the potential supply of NF beds for long term care; (2) evaluate the potential demand for NF beds for long term care by considering the needs of the whole population; and (3) review the overall seismic capability of San Francisco's acute hospital buildings to accommodate NF beds. The Study's findings are intended to assist in strategic planning regarding the need for long term care services, and the future availability of NF beds in San Francisco.

Laguna Honda Hospital, owned by the City and County of San Francisco and operated as a division of the Department of Public Health (DPH), is the largest municipally owned single-site long term care facility in the nation. However, the principal buildings are now old and have serious physical deficiencies. To face the challenge of providing long term health care services to the City's increasing elderly and disabled population, DPH initially developed a proposal to replace existing structures with a new, modern 1,207 bed facility.

In FY 1994-95, this proposal was reevaluated because: (1) the new, large long term care facility would be expensive, at a 1994-95 cost of \$482 million; (2) significant changes in health care services delivery precluded such a substantial financial commitment; and (3) the increasing emphasis on home and community-based long term care options needed to be evaluated. In addition, (4) the future utilization of acute beds in San Francisco's hospitals needed to be fully explored.

While some financial information is provided, this Study is considered a capacity analysis - not a financial analysis. A financial analysis would assist in determining the financial feasibility for hospitals to convert acute beds to NF beds. Such an analysis may be the next step in evaluating the potential of converting acute beds to NF beds, in order to address a portion of the demand for long term care.

Each hospital is continuously involved in its own strategic planning process, attempting to improve efficiency and strengthen its place in the San Francisco health care market. The information provided within the individual hospital profiles, found in the Appendices, reflects the position of each hospital at the time of the interview. It is entirely possible that some of this information may not reflect the plans of a particular hospital after June of 1996.

## 2. Comprehensive Summary of Findings, Trends & Projections

### The Potential Supply of NF Beds for Long Term Care:

⇒ San Francisco currently has a total of 3,625 NF beds. This includes:

Laguna Honda Hospital	1,214
The Jewish Home for the Aged	437
Hospital-Based Nursing Facilities	450
Freestanding Nursing Facilities	1,404
VA Nursing Home	<u>120</u>
	3,625 NF Beds

⇒ An opportunity exists to convert acute care beds in hospitals to address long term care demand, although the actual potential may be less than the perceived potential.

- Total available bed capacity, which includes beds a hospital could reactivate if necessary for inpatient service delivery, is 3,687 beds.
- Reducing the total available bed capacity by the existing 450 NF beds in hospitals provides the total available acute bed capacity of 3,237 NF beds.
- By deducting the acute average daily census of 1,783 beds (June 1996), the total potential acute beds available for conversion to NF beds is 1,454 beds.
- But seasonal fluctuations in bed need and emergency preparedness reduce the total potential acute beds available for conversion to 1,090 beds.

⇒ The chart below represents a snapshot of bed capacities in hospitals as of June 1996.

**Bed Capacities in Hospitals, June 1996**

Hospital Name	Total Available Beds	Total Available Acute Beds	Acute Average Daily Census	Difference
Chinese Hospital	59	59	36	23
California Pacific Medical Center	434	337	228	109
Kaiser Medical Center	226	226	151	75
Davies Medical Center	323	272	44	228
San Francisco General Hospital	357	338	270	68
Saint Francis Memorial Hospital	225	191	82	109
St. Luke's Hospital	180	101	70	31
St. Mary's Medical Center	496	448	173	275
UCSF Medical Center/Mount Zion	815	784	441	343
VA Medical Center	244	244	155	89
Pacific Coast Hospital	28	28	1	27
Seton Medical Center*	300	209	132	77
<b>SUBTOTALS</b>	<b>3,687</b>	<b>3,237</b>	<b>1,783</b>	<b>1,454</b>
Seasonal fluctuations in bed need and emergency preparedness				- 364
<b>TOTAL</b>				<b>1,090</b>

\*NOTE: Seton Medical Center is included because of its geographic proximity.



⇒ However, San Francisco hospitals estimated that there existed as of June 1996 a total projected surplus of 314 acute beds. Of that surplus, a total potential of 271 acute beds were available for conversion to NF beds to address a portion of the demand for long term care in the immediate future.

- Hospitals explain that limited acute care bed space is available for conversion to NF beds for a variety of reasons. These include:
  - census numbers reflect midnight activity only.
  - the expansion or consolidation of health care programs.
  - mergers.
  - research space.
  - unfinished strategic planning processes.
  - participation in regional delivery systems.
  - a need to retain surplus acute care beds in San Francisco.
  - beds are governed by organizations that solely determine their availability.

### **Trends in Long Term Care Service Delivery:**

- ⇒ Long term care is a set of health care, personal care, and social services delivered over a sustained period of time to persons whose capacity to live independently is compromised by physical, mental, or cognitive limitations.
- ⇒ Long term care can be provided both in institutional settings and in home and community-based settings.
- ⇒ The need for long term care is generally defined by limitations in the ability of individuals to independently perform basic self care and household tasks. These persons require help with either: (1) the activities of daily living (ADLs); or (2) the instrumental activities of daily living (IADLs).

<b><u>Activities of Daily Living</u></b> <b>(ADLs)</b>	Generally include eating, bathing, dressing, getting to and using the bathroom, getting in or out of a bed or chair, and mobility.
<b><u>Instrumental Activities of Daily Living</u></b> <b>(IADLs)</b>	Generally include going outside the home, keeping track of money or bills, preparing meals, doing light housework, using the telephone, and taking medicine.

- ⇒ Cost and rapid population growth are driving changes in long term care services delivery throughout the country.
  - Various factors including cost and appropriate care in the appropriate setting are generating efforts to increase home and community-based services, and reduce the emphasis on institutional care.



- Emerging models of long term care service delivery now being developed by states throughout the U.S. emphasize:

- greater reliance on home and community-based services.
- consolidation of administrative responsibility for long term care.
- development of residential options, including supportive housing as part of the continuum of long term care.
- less reliance on institutional care.

⇒ Three states have developed innovative models for the delivery of long term care services for elderly and disabled persons. Each has a long-standing Medicaid Waiver program to fund home and community-based care for people who meet Medicaid eligibility requirements and would otherwise require institutional care.

- **Oregon** operates under a policy that increases emphasis on home and community-based services, and decreases emphasis on nursing facilities.

- As part of its Medicaid waiver program, the state has actively developed non-institutional alternative living arrangements for long term care beneficiaries, with emphasis on alternative residential settings such as adult foster homes and assisted living facilities.
- Oregon's model of service delivery includes a policy promoting independence and choice for elderly and disabled persons, and a certificate of need requirement for nursing homes.
- Oregon's NF bed ratio in 1996 is 27 beds per 1,000 persons age 65 and over, which is the lowest ratio in the country.
- Of the population eligible for long term care in 1996, 54.7% are in alternative residential settings, and 45.3% reside in nursing facilities.

- **Washington** has a formal policy to deliver long term care through home and community-based settings whenever possible.

- Washington has four home and community-based care programs, including a Medicaid waiver program, a nonwaiver Medicaid personal care program, and two state-funded programs for persons who do not qualify for Medicaid.
- Washington also has a substantial freestanding nursing facility program that includes a certificate of need requirement.
- Washington's NF bed ratio in 1996 is 45 beds per 1,000 persons age 65 and over, which is close to the national average of 50 beds per 1,000 persons age 65 and over.
- Of the beneficiaries receiving Medicaid or state-supported long term care during an average month in 1993, 55.8% were in home and community-based settings, and 44.2% were in nursing facilities.

- **Wisconsin**, which has one of the highest ratios of nursing facility beds to its elderly population, has been able to constrain Medicaid nursing facility utilization and moderate growth in expenditures, while serving more long term care beneficiaries with home and community-based care.

- Wisconsin provides home and community-based long term care services for aged and physical disabled persons with through Medicaid home health and personal care services, a Medicaid waiver program, and the state-funded Community Options Program.
- Wisconsin's NF bed ratio in 1992 was 72 beds per 1,000 persons 65 and over, which was one of the highest in the country.
- Of the beneficiaries receiving Medicaid or state-supported long term care in 1992, Wisconsin served 31.5% in home and community-based settings compared with 68.5% in nursing facilities.

⇒ Many states are adopting strategies to reduce the need for additional nursing facility beds by developing new types of supportive housing for their growing elderly and disabled populations. These include: (1) congregate housing, (2) adult foster care homes, (3) residential care facilities, and (4) assisted living facilities.

⇒ California has created a long term care integration pilot program called AB 1040.

- This will create five long term care pilot projects to test a variety of models which provide a continuum of services that foster independence and allow consumers to remain integral parts of their communities.

- The City and County of San Francisco has expressed an interest in participation, to develop a delivery system model that allows long term care consumers to remain integral parts of their communities, prevents unnecessary use of acute care hospitals, and promotes greater efficiencies.

- The Board of Supervisors established the Long Term Care Pilot Project Task Force in November 1996. Task Force members were appointed in April 1997. The process to create a comprehensive long term care plan began in May 1997.

⇒ Long term care services in San Francisco are currently provided in Laguna Honda Hospital, other hospital-based nursing facilities and freestanding nursing facilities, and a variety of home and community-based programs.

⇒ One innovative home and community-based service provider is On Lok Senior Health Services, a Medi-Cal and Medicare managed care capitated program.

- On Lok's PACE Program (Program of All Inclusive Care for the Elderly) provides comprehensive and coordinated community-based health and social services to nursing facility certifiable elders.

- On Lok operates PACE programs at four locations that serve the east and south east portions of the City.

- In collaboration with the Goldman Institute on Aging, On Lok has replicated its PACE program at a new location for nursing facility certifiable elders who live in unserved communities in the western portion of the City.

⇒ Subacute care is being promoted as a cost-effective alternative to inpatient acute hospital care.

- Many patients who previously remained in an acute bed are now being discharged after a shorter period to their home, or to placement in a nursing facility, or a subacute care setting.

- California instituted a subacute level of care in 1986, called the Adult Subacute Care Program. This program is for medically fragile persons including quadriplegics, paraplegics, and persons with tracheotomies.

- California is expanding subacute services through the creation of the Transitional Inpatient Care (TIC) Program. This provides access to quality medical and/or rehabilitative care to Medi-Cal beneficiaries who are medically stable with short-term transitional care needs.

### **The Future Demand for Total Long Term Care:**

⇒ The future demand for total long term care in the U.S. and San Francisco will be based on the needs of specific groups. These include: (1) elderly persons, (2) persons with disabilities, (3) chronically ill persons, (4) persons with AIDS, and (5) terminally ill persons.

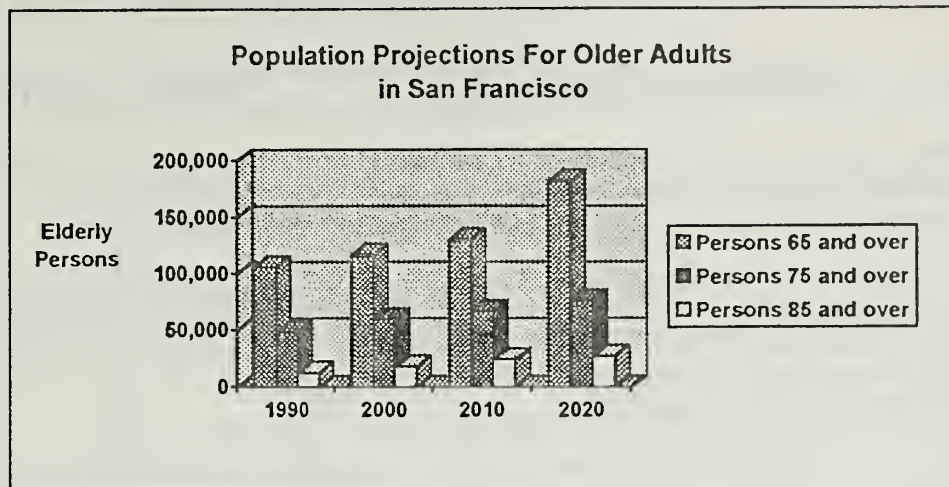
⇒ While many individuals within each of these groups will require long term care, reliable population projections are only available for elderly persons (the vast majority of the defined population).

#### **State Department of Finance Projections for San Francisco**

	<b>2000</b>	<b>2010</b>	<b>2020</b>
<b>Population total</b>	774,011	781,735	777,391
<b>Persons 65 and over</b>	116,080 (15.0%)	129,787 (16.6%)	181,981 (23.4%)
<b>Persons 75 and over</b>	59,523 (7.70%)	66,483 (8.50%)	75,346 (9.69%)
<b>Persons 85 and over</b>	17,718 (2.30%)	23,958 (3.10%)	26,832 (3.40%)



⇒ The following chart depicts these projections for elderly persons in San Francisco.



⇒ Eight states in the U.S. are expected to double their elderly populations (persons 65 and over) by 2020.

⇒ California's elderly population will double from 3.30 million in 1993 to 6.62 million by 2020, and will be the largest in the nation.

**U.S. Census Bureau Projections for States  
With Doubling Elderly Populations (65 and over) by 2020**

	1993	2020	Percent Change
Nevada	155,000	333,000	115.6%
Arizona	529,000	1,121,000	111.9
Colorado	357,000	743,000	108.0
Georgia	695,000	1,419,000	104.0
Washington	612,000	1,245,000	103.5
Alaska	26,000	54,000	103.3
Utah	165,000	334,000	102.4
<b>California</b>	<b>3,303,000</b>	<b>6,622,000</b>	<b>100.5</b>

⇒ The precise number of elderly persons who will require long term care in the future is difficult to project. However, there are several indicators, based on both national and local experience, that can be taken into consideration in estimating the potential demand generated by San Francisco's elderly for long term care in the future.

### Indicators of Demand For Total Long Term Care for the Elderly

Indicators of Demand	2000	2010	2020
<b>Indicator Number 1:</b> Persons 65 and over with mobility and self-care limits, living in the community, who may need some level of care (9.7% of persons 65 and over).	11,296	12,589	17,652
<b>Indicator Number 2:</b> Persons 85 and over - the frail elderly - who may need assistance with activities of daily living (51% of persons 85 and over).	9,306	12,128	13,684
<b>Indicator Number 3:</b> Persons 85 and over - the frail elderly - who may require comprehensive long term care services (10% of persons 85 and over).	1,778	2,396	2,683

### The Future Demand for Nursing Facility (NF) Beds:

- ⇒ The future demand for NF beds in the U.S. and San Francisco will be comprised of the needs for: (1) short term traditional nursing facility care; (2) short term subacute care (including medical subacute and rehabilitation subacute care, other types of stepdown units, and transitional inpatient care); and (3) institutional long term care.
- ⇒ This demand will be based on the needs of specific populations for short term and long term care, including: (1) persons recovering from acute episodes who require traditional nursing facility care; (2) persons recovering from acute episodes who require subacute care; and (3) persons who require institutional long term care, including the frail elderly and those with chronic conditions, disabilities, and AIDS.
- ⇒ Individuals who will require institutional long term care may primarily consist of those with heavy care needs such as: (1) medically complex patients; (2) agitated demented wanderers; (3) physically dependent individuals who require two-to-three person transfers; (4) those who require extensive nursing hours; (5) dually and triply diagnosed patients; (6) those who don't relate to their surroundings; (7) those who have no family support; and (8) those who have no financial resources.
- ⇒ The future demand for NF beds can be evaluated in relationship to the expanding capacity of home and community-based long term care service providers.
- ⇒ Because it is not yet apparent what will occur in San Francisco concerning where long term care services can or will be delivered, three different assumptions concerning NF bed demand projection scenarios are provided based on:

- Oregon's experience, with a NF bed use rate of 27 NF beds per 1,000 persons over age 65;
- San Francisco's current situation, with a NF bed use rate of 33 NF beds per 1,000 persons over age 65; and
- Washington's experience, with a NF bed use rate of 45 NF beds per 1,000 persons over age 65.

### **Demand for NF Beds Projected to 2000, 2010, & 2020**

	<b>2000</b>	<b>2010</b>	<b>2020</b>
<b><u>Scenario 1</u></b> (based on Oregon's experience)	<b>3,831</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>3,894</b> <b>NF Beds</b> (30 NF beds per 1,000 persons over 65)	<b>4,913</b> <b>NF Beds</b> (27 NF beds per 1,000 persons over 65)
<b><u>Scenario 2</u></b> (based on San Francisco's current situation)	<b>3,831</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>4,282</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>6,005</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)
<b><u>Scenario 3</u></b> (based on Washington's experience)	<b>3,831</b> <b>NF Beds</b> (33 NF beds per 1,000 persons over 65)	<b>4,802</b> <b>NF Beds</b> (37 NF beds per 1,000 persons over 65)	<b>8,189</b> <b>NF Beds</b> (45 NF beds per 1,000 persons over 65)

- ⇒ The demand and the supply of NF beds can be projected to 2000, 2010 and 2020. These projections are applied to the three scenarios presented above. The remaining deficit of NF beds is related to the different NF bed use rates employed to establish each scenario.
- ⇒ The projections assume that Laguna Honda Hospital would be maintained until sometime after 2000.
- ⇒ For purposes of this Study only, it is assumed that Laguna Honda Hospital could be replaced by a smaller long term care facility of 600 beds by 2010. This new facility would be targeted for the most medically complex Medi-Cal and medically indigent adult patients, for whom home and community-based care is not an option.
- ⇒ The projections also assume that the equivalent of one 350 bed acute care hospital could be converted to a long term care facility between 2001 and 2010, and that the equivalent of a second 350 bed acute care hospital could be converted to a long term care facility between 2011 and 2020.



## Period One: 1997 to 2000

**Summary of elderly population growth in this period.** By 2000, the number of persons 65 and over is projected to increase by 10,700, from 105,380 persons in 1990 to 116,080 persons. There will also be a projected increase of 5,570 persons over the age of 85, from 12,148 persons in 1990 to 17,148 persons in 2000.

### Projected Demand and Supply of NF Beds from 1997 to 2000

	Scenario 1	Scenario 2	Scenario 3
<b>Projected Demand for NF Beds:</b>	<b>3,831</b> (33 NF beds per 1,000 persons over 65)	<b>3,831</b> (33 NF beds per 1,000 persons over 65)	<b>3,831</b> (33 NF beds per 1,000 persons over 65)
<b>Projected Supply of NF Beds:</b>			
• Maintain existing Laguna Honda Hospital	- 1,214	- 1,214	- 1,214
• Maintain the Jewish Home for the Aged	- 437	- 437	- 437
• Maintain Hospital-Based Nursing Facilities	- 450	- 450	- 450
• Maintain Freestanding Nursing Facilities	- 1,404	- 1,404	- 1,404
• Maintain VA Nursing Home	- 120	- 120	- 120
<b>Subtotal</b>	<b>3,625</b>	<b>3,625</b>	<b>3,625</b>
<b>Difference</b>	<b>206</b>	<b>206</b>	<b>206</b>
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	<b>- 271</b>	<b>- 271</b>	<b>- 271</b>
<b>Deficit of NF Beds</b>	<b>0</b>	<b>0</b>	<b>0</b>

## Period Two: 2001 to 2010

**Summary of elderly population growth in this period.** By 2010, the number of persons 65 and over is projected to increase by 13,707, from 116,080 persons in 2000 to 129,787 persons. There will also be a projected increase of 6,240 persons over the age of 85, from 17,718 persons in 2000 to 23,958 persons in 2010.

### Projected Demand and Supply of NF Beds from 2001 to 2010

	Scenario 1	Scenario 2	Scenario 3
<b>Projected Demand for NF Beds:</b>	<b>3,894</b> (30 NF beds per 1,000 persons over 65)	<b>4,282</b> (33 NF beds per 1,000 persons over 65)	<b>4,802</b> (37 NF beds per 1,000 persons over 65)
<b>Projected Supply of NF Beds:</b>			
• Develop a new Laguna Honda Hospital	- 600	- 600	- 600
• Maintain the Jewish Home for the Aged	- 437	- 437	- 437
• Maintain Hospital-Based Nursing Facilities	- 450	- 450	- 450
• Maintain Freestanding Nursing Facilities	- 1,404	- 1,404	- 1,404
• Maintain VA Nursing Home	- 120	- 120	- 120
• Convert one Hospital to a LTC Facility	- 350	- 350	- 350
<b>Subtotal</b>	<b>3,361</b>	<b>3,361</b>	<b>3,361</b>
<b>Difference</b>	<b>533</b>	<b>921</b>	<b>1,441</b>
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	<b>- 271</b>	<b>- 271</b>	<b>- 271</b>
<b>Deficit of NF Beds</b>	<b>262</b>	<b>650</b>	<b>1,170</b>

### Period Three: 2011 to 2020

Summary of elderly population growth in this period. By 2020, the number of persons 65 and over is projected to increase by 52,194, from 129,787 persons in 2010 to 181,981 persons. There will also be a projected increase of 2,874 persons over the age of 85, from the 23,958 persons in 2010 to 26,832 persons in 2020.

#### Projected Demand and Supply of NF Beds from 2011 to 2020

	Scenario 1	Scenario 2	Scenario 3
<b>Projected Demand for NF Beds:</b>	<b>4,913</b> (27 NF beds per 1,000 persons over 65)	<b>6,005</b> (33 NF beds per 1,000 persons over 65)	<b>8,189</b> (45 NF beds per 1,000 persons over 65)
<b>Projected Supply of NF Beds:</b>			
• Maintain new Laguna Honda Hospital	- 600	- 600	- 600
• Maintain the Jewish Home for the Aged	- 437	- 437	- 437
• Maintain Hospital-Based Nursing Facilities	- 450	- 450	- 450
• Maintain Freestanding Nursing Facilities	- 1,404	- 1,404	- 1,404
• Maintain VA Nursing Home	- 120	- 120	- 120
• Maintain new LTC Facility	- 350	- 350	- 350
• Convert 2nd Hospital to a LTC Facility	- 350	- 350	- 350
<b>Subtotal</b>	<b>3,711</b>	<b>3,711</b>	<b>3,711</b>
<b>Difference</b>	<b>1,202</b>	<b>2,294</b>	<b>4,478</b>
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	- 271	- 271	- 271
<b>Deficit of NF Beds</b>	<b>931</b>	<b>2,023</b>	<b>4,207</b>

⇒ Following is a summary of the demand and supply of NF beds in San Francisco, projected to 2000, 2010 and 2020. The remaining deficit of NF beds is related to the different NF bed use rates employed to establish the projected demand.

#### Future NF Bed Demand and Supply Summary

	2000	2010	2020
<b>Projected Demand for NF Beds</b>	3,831	3,894 - 4,802	4,913 - 8,189
<b>Projected Supply of NF Beds</b>	3,625	3,361	3,711
<b>Difference</b>	206	533 - 1,441	1,202 - 4,478
<b>Impact of Converting Projected Surplus Acute Beds to NF Beds</b>	- 271	- 271	- 271
<b>Deficit of NF Beds</b>	0	262 - 1,170	931 - 4,207

## Observations:

⇒ Managed care may have an impact on the availability of acute beds.

- Due to managed care, many experts estimate that the City's average daily census may drop from 1,783 acute beds (in June 1996) to approximately 1,000 acute beds by 2000.
- Should this occur, additional acute beds may be available to address the increasing demand for long term care.

⇒ Hospitals expressed interest in converting acute beds to long term care beds.

- Several hospitals expressed interest in exploring opportunities to develop additional NF beds in their institutions, but were concerned about:
  - financial incentives for capital costs associated with the conversion of acute units to nursing facility units.
  - adequate reimbursement to cover the cost of heavy care patients.
  - referrals of patients.
  - sharing risk for the provision of institutional long term care.
  - regulatory requirements and licensing issues related to conversion.
- Some hospitals expressed an interest in relationships to provide additional NF beds. Proposals include:
  - leasing space within their institution.
  - shared ownership.
  - joint subsidy of conversion.
- Some hospitals, which provide limited or no nursing facility services, expressed interest in exploring opportunities to refer patients to other facilities that may have additional NF bed capacity. Proposals include:
  - leasing excess NF bed capacity in other institutions for either post-acute or long term care.
  - joint ventures with other institutions for the development of additional NF bed capacity.



⇒ In the near future, new seismic regulations will influence the conversion of acute hospital buildings to nonacute uses.

- Current law establishes seismic safety standards for hospital buildings constructed on or after March 7, 1973. SB 1953 requires OSHPD to develop new standards for buildings constructed before March 7, 1973.
- After January 1, 2008, hospital buildings that do not meet the new standards may be used only for nonacute care and administrative purposes.
- Attention needs to be given to leasing or converting acute care units for nursing facility services.
- Following a seismic evaluation, all hospital buildings designed and constructed before March 7, 1973 will fall into either a Structural Performance Category (SPC) level 1 or 2.
- Hospital buildings placed in SPC level 1 may collapse during or after an earthquake, posing a significant risk and danger to the public.
- Hospital buildings placed in SPC 2, 3, 4, or 5 are reasonably capable of providing services following an earthquake, or may suffer some damage during an earthquake but not collapse or significantly jeopardize life.



**Concept Paper for  
San Francisco's Long-Term Care Integration  
Pilot Project**

**EXECUTIVE SUMMARY**

For submission to:  
The Office of Long-Term Care  
California Department of Health Services

**Department of Public Health  
City and County of San Francisco**

**DRAFT: August 26, 1998**



## EXECUTIVE SUMMARY

San Francisco is proposing a new model of service delivery that will allow long-term care consumers to remain integral members of their communities. Aging, chronic conditions, and functional and/or cognitive limitations create the need for long-term care. The foundation of this new model is an innovative vision of health and well-being for older and disabled adults who need care. Its realization will enable consumers to live as independently as possible.

Currently, San Francisco has an uncoordinated array of long-term care programs and services. There are service gaps and duplications. Consumers have insufficient choices regarding where services will be provided, and the current focus is on institutional care. More disturbing is the limited emphasis placed on consumer needs.

The new model of service delivery recognizes the consumer's desire to have choices in service settings and to remain at home for as long as possible. It acknowledges the consumer's request for high quality services in the least restrictive, suitable environment. Accordingly, it stresses the importance of community-based care and in-home support programs, while recognizing the continuing value of institutional care.

In order to create this new model, restructuring and improving the service delivery system will be necessary to shift the focus to the comprehensive needs of the consumer. The delivery system will be organized to enhance consumer choice and maintain quality of life. Consumers will be able to receive services in their homes, in community-based settings, and in institutional settings. To enable the integration of long-term care and acute care services for consumers, the delivery system will develop a number of service provider networks. Each will offer network case management, which will be the cornerstone of care coordination. As a result of network case management, the most appropriate care will be provided for each consumer, responsibly and flexibly.

In the fall of 1995, Governor Wilson signed AB 1040 to create the Long-Term Care Integration Pilot Program to improve the delivery system for long-term care services for frail elderly and disabled residents throughout the state. The overall goal of the program is to make California's long-term care system more responsive to individual needs.

The objectives of California's Long-Term Care Integration Pilot Program are to:

- provide a continuum of social and health services that foster independence and self-reliance, and allow consumers to remain an integral part of their family and community.
- if out of home placement is needed, to ensure that it is at the appropriate level of care and to prevent the unnecessary use of acute care hospitals.
- deliver services in the least restrictive environment appropriate for the consumer.
- achieve greater efficiencies through consolidated screening and reporting requirements.
- test a variety of models, and to allow each project site to use existing funding sources in a manner it determines will meet local need and that is cost-effective.

In February 1996, San Francisco Mayor Willie Brown and Kevin Shelley, then president of the San Francisco Board of Supervisors, informed the State Department of Health Services of the City's interest in developing a Long-Term Care Integration Pilot Project. In keeping with the State's intent, San Francisco's objectives for its Pilot Project are to develop a delivery system model that:

- offers a comprehensive continuum of long-term care services.
- provides improved access to these long-term care services.
- allows consumers to remain integral parts of their communities.
- stresses the importance of community-based and in-home support programs.
- expands care in the least restrictive settings possible.
- prevents unnecessary utilization of acute care hospitals.
- promotes greater efficiencies.

Long-term care is defined as assistance on an intermittent or continuous basis over a sustained period of time for people whose capacity to live independently is compromised by physical, mental, or cognitive impairments.<sup>1</sup> Long-term care services can be provided in home and community-based settings, and in institutional settings. San Francisco has a large and growing elderly population, many of whom will require long-term care. Increasing numbers of younger disabled and chronically ill persons in the City also require long-term care.

The need for long-term care is generally defined by limitations in the ability of individuals to independently perform basic self-care and household tasks. Those who need long-term care assistance are persons who require help with either: (1) the activities of daily living (ADLs) such as eating, dressing, bathing, getting in or out of bed, or using the toilet; or (2) the instrumental activities of daily living (IADLs) such as housekeeping, buying groceries, or managing money.

The primary recipients of long-term care are older adults because of the higher prevalence of chronic illness in this population. Other recipients include younger disabled adults, persons with chronic illnesses and chronic infectious diseases such as tuberculosis and AIDS, and persons with mental illness or developmental disabilities. Chronic illness may lead to increasing disability or functional impairment.

The total demand for long-term care in San Francisco will be based on the needs of specific groups, including: (1) elderly persons; (2) persons with disabilities; (3) persons with chronic conditions; (4) persons with cognitive impairment; (5) persons with AIDS; and (6) terminally ill persons. At the present time, between 50,000 to 55,000 San Francisco residents certified for Medi-Cal services are either aged, blind, or disabled. This group represents the total Medi-Cal population that may need medical and social services. A portion of this group will require long-term care services during the first phase of service delivery.

By 2020, the number of persons aged 65 and over is projected to be 181,981 (23.4% of the City's total population). The substantial increase in the elderly population - approximately 66,000 - above the number of persons aged 65 and over in 2000 is forcing the City to explore appropriate



long-term care service delivery systems for our elderly and disabled populations. Also by 2020, the number of younger adults aged 18 to 64 is projected to be 464,962 (59.8% of the total population). A portion of each of these age groups will require long-term care services.

Currently, long-term care services in San Francisco include an uncoordinated array of categorical programs offering health, medical, social, and other support services funded and administered by different federal, state and local agencies. There are gaps, duplication in services, and little emphasis on the coordinated needs of the consumer.

A variety of in-home and community-based programs exist. In addition, several institutional settings exist in which long-term care services are provided, including: (1) Laguna Honda Hospital, the largest single-site, publicly run, long-term care facility in the United States; (2) the Jewish Home for the Aged; (3) eight hospital-based nursing facilities; and (4) a number of freestanding nursing homes.

### **The Long-Term Care Pilot Project Task Force**

The San Francisco Board of Supervisors established the Long-Term Care Pilot Project Task Force in November 1996. Task Force members were appointed in April 1997. This 27 member body consists of service providers, consumers, community advocates, health care professionals, supportive housing advocates, a variety of city agencies, and representatives of managed care organizations, hospitals, nursing facilities, residential care facilities, business, and labor.

The process of developing a Long-Term Care Integration Pilot Project began in May 1997. Throughout this process, the Department of Public Health acted as lead agency. San Francisco utilized a public/private partnership in planning this effort to ensure that the Pilot Project demonstrates how both public and private providers can work together to create an integrated spectrum of long-term care services. To assist the Task Force in developing the components of the new long-term care service delivery model, five Design Teams (Service Delivery, Scope of Services, Resource Allocation and Financing, Supportive Housing, and Consumer Issues) were created. These Design Teams began meeting in July 1997. To obtain input from consumers, family caregivers, and advocates regarding long-term care services, the Task Force held five community forums in October 1997.

### **The Broad Program Vision of the Pilot Project**

To consolidate and manage a service delivery system that includes a full continuum of social and medical services, and effectively addresses consumer needs, a long-term care services agency will be established to develop multiple service provider networks. Each network will provide the full continuum of social and medical services to meet consumer needs. To afford consumer choice, all networks will offer options for case management, including: (1) consumer directed care for persons requiring minimal assistance and support; (2) services case management for persons requiring more frequent support and supervision; and (3) provider directed care for physically and mentally frail persons who require a maximum amount of care and supervision.



This new model of service delivery will be organized from the consumer's point of view. It will be based on consumer needs, and not solely on provider reimbursement. However, it will operate within the constraints of available financial resources. While ensuring that a major restructuring of the delivery system will occur, this new model of service delivery will also capitalize on the innovation and creativity of San Francisco's existing long-term care service providers. By doing so, it will build upon the foundation of successful delivery systems that already exist.

A seamless system of care will be created for individuals who need long-term care services. The following are some of the elements of the new service delivery model that will address the deficiencies and overlaps in the existing system:

- multiple initial contact locations,
- single point of entry,
- eligibility determination and certification,
- improved availability of information,
- access to an array of services,
- network case management,
- single comprehensive intake and assessment,
- consumer participation in development of the care plan,
- integrated long-term care services, and
- continuous monitoring of consumer satisfaction and quality assurance.

The long-term care services agency will establish the values of the service delivery system and determine the requirements and characteristics that will guide the formation of the multiple provider networks. This agency will foster and ensure mutual accountability among service providers on behalf of consumers. It will set standards for the quality of service delivery and establish outcome objectives for consumer care. It will separate overall administrative functions from service delivery functions, which are the responsibility of the provider networks. The long-term care services agency will also: (1) negotiate a capitated budget with the State Department of Health Services; (2) administer the consolidated long-term care services fund; and (3) bear financial risk for the Pilot Project.

The consolidated long-term care services fund will include all Medi-Cal and other State funds supporting services for the initial target population. As soon as possible, after this Pilot Project is implemented with Medi-Cal funds, Medicare funds will be incorporated into the consolidated fund. Over time, as additional population groups are incorporated into the Pilot Project, related program funds will be incorporated into the consolidated fund.

The organization of service providers into networks will foster innovative service design and delivery. Providers that desire to develop more comprehensive delivery systems will use their creativity and business ingenuity to organize a range of services in the best interest of the consumers. Networks will develop services based on their own values and standards, and those established by the long-term care services agency. Each network will incorporate all necessary home and community-based services as well as institutional services required to serve consumers

with long-term care needs. The services provided by networks will continually be adjusted to meet changing consumer needs.

The target population for the broad program vision encompasses all persons 18 years of age and older requiring long-term care, who need assistance with one or more activities of daily living (ADLs), and/or meet the definition of cognitive impairment. This broad target population includes Medi-Cal eligible elderly and disabled adults, as well as persons not eligible for Medi-Cal. It incorporates persons with long-term mental illness, persons with HIV/AIDS, and the developmentally disabled. The goal is the complete incorporation of all of these population groups into the target population as soon as possible.

Persons with cognitive impairment (resulting from Alzheimer's disease, other dementias, stroke, Parkinson's disease, or head injury), who may not need help performing ADLs, are included in the target population – both in the broad program vision and the first phase. Although such persons may not need assistance performing ADLs, they may require supervision and prompting. In addition, persons already included in the target population, who also have mental health conditions, will be treated through the continuum of services provided by the Pilot Project.

The scope of services provided through the delivery system must take into account the wide variation of age, values, and disability levels of consumers in need of assistance. The scope of services needs to be flexible enough to accommodate the goals of consumers, which range from: (1) promoting the highest level of independence, to (2) maintaining functional abilities in order to prevent further disability. The intent of the Pilot Project will be to help consumers obtain the services they need, within the constraints of available financial resources. The scope of services will be organized in a manner that reflects the consumer perspective, as follows:

- ◆ At-home services.
- ◆ Community-based services.
- ◆ Co-location of housing and services.
- ◆ For some consumers, center-based services.
- ◆ Institutional services.
- ◆ Optimal use of transportation services.

The availability of appropriate and affordable housing has emerged as a critical component of an effective long-term care service delivery system. It is essential that the fiscal, health, and social advantages of supportive residential settings, in which home and community-based services can be provided, be acknowledged. At the same time, it is important to recognize the need for, and value of, institutional care. San Francisco will need residential and institutional settings in which long-term care services can be provided.

Toward this end, the City will need to develop services designed to support older and disabled adults to remain in their own homes. For those who cannot remain at home, the City will need to develop a number of different supportive housing options, including service enriched housing, assisted living, housing with co-located services, residential care facilities, PACE programs with housing; and nursing facilities. To expand housing options for older and disabled adults, the



Task Force recommends that the City: (1) maintain the existing stock of residential care facilities, (2) develop new residential care facilities, (3) develop additional units of supportive housing, (4) make supportive housing available throughout San Francisco, and (5) develop increased capacity in nursing facilities.

In April 1998, the San Francisco Health Commission reviewed issues related to Laguna Honda Hospital's physical plant and directed the Department of Public Health to develop a plan to replace the facility. The existing resident care buildings do not comply with contemporary hospital construction and seismic safety standards. In July 1998, the Health Commission adopted a resolution to support a general obligation bond to rebuild and retrofit Laguna Honda Hospital. The future of Laguna Honda Hospital is being evaluated within the context of the City's efforts to expand long-term care services. This new publicly-operated facility will serve San Franciscans who require long-term care in an institutional setting.

### **Options For The Long-Term Care Services Agency**

A number of possibilities have been explored by the Task Force to establish the governance structure for the Pilot Project. However, no organizational entity has been designated to become the permanent long-term care services agency. Before a permanent designation is made, a transitional long-term care services agency will be established.

During the detailed planning phase of the Pilot Project, issues and options concerning the initial governance structure will be completely evaluated. Based on this investigation, the Task Force will present its recommendations to the San Francisco Health Commission for the designation of a transitional long-term care services agency.

This transitional agency will be replaced by a permanent governance structure after a more in-depth exploration of options is completed. Based on its initial investigations, the Task Force anticipates that this transitional agency may either be: (1) a permanent, separate Long-Term Care Public Authority; or (2) integrated into the San Francisco Health Authority. However, the Task Force expects that other options may also exist. These may include: (3) the governance structure being developed to expand health care coverage to the uninsured; (4) the governance structure that may be established for a county-organized health system; or (5) the governance structure that may be established through a Medicaid 1115 waiver. All of these options for a permanent governance structure for the Long-Term Care Pilot Project will be explored.

### **A Detailed Planning Phase To Establish Initial Governance Structure**

The detailed planning phase will establish the initial governance structure for the Pilot Project. This phase will include research required for the designation of the transitional long-term care services agency, and the development of administrative structures and functions required to implement the next phase of the Pilot Project.



The Department of Public Health ("the Department") will continue in its role as lead agency for the Pilot Project. To continue the work of the Task Force, the Department will oversee the initial development of some of the administrative structures and functions required to implement the first phase of service delivery under fee-for-service managed long-term care. The completion of these administrative structures and functions will be the responsibility of the transitional long-term care services agency.

The successful implementation of this Pilot Project will require the City's resources as well as resources from the private sector. The Department will explore the potential to obtain financial assistance from foundations to support the work of the transitional long-term care services agency. Over a three to four year period, depending on the option selected for permanent governance structure, it is estimated that \$2 million may be required for start-up costs.

The Task Force will continue to function until it completes all components of a comprehensive plan for long-term care pursuant to the State's Long-Term Care Integration Pilot Program. In collaboration with the Department, the Task Force will evaluate all alternatives and recommend a transitional long-term care services agency to the Health Commission. When the Task Force presents its comprehensive plan to the Board of Supervisors, it will automatically terminate.

### **The First Phase of Service Delivery:** **Implementation of Fee-For-Service Managed Long-Term Care**

The first phase of the Pilot Project involving service delivery will be implemented under fee-for-service managed long-term care. This will be solely for the initial target population. The first phase is anticipated to last three years. It will focus on improving coordination of long-term care services and programs. Under fee-for-service managed care, risk and payment for services will remain at the State level. The transitional long-term care services agency will assume some of the responsibilities of the State Medi-Cal Field Office, such as authorizing services locally.

One of the primary components of the first phase will be the collection and analysis of service and expenditure data. Data gathering will assist in assessing utilization and costs associated with serving specific population groups through the existing long-term care service delivery system. Data analysis will assist in determining if service overlaps and duplications are occurring, and can assist in achieving overall system efficiencies.

The transitional long-term care services agency will establish the requirements for the formation of formal provider networks that will operate under capitation. Provider network capitation mechanisms, and payment and risk sharing options will be developed. An 1115 waiver will be sought to enable the pooling of Medi-Cal funds to support provider networks and enable service substitutions. Also, as soon as possible, a 222 waiver will be explored to obtain Medicare funds for inclusion in the consolidated fund. Labor organizations representing employees currently involved in long-term care will continue to be involved in all phases of planning.

The initial target population includes older and disabled adults who are Medi-Cal eligible, 18 years of age and over, who require assistance with two or more activities of daily living, and/or meet the definition for cognitive impairment. Persons who are dually eligible for Medi-Cal and Medicare are included within the initial target population. In addition, persons already included in the initial target population with secondary mental health conditions will be treated through the continuum of services provided by the Pilot Project.

Mandatory enrollment will be required for all Medi-Cal eligible older and disabled adults included in the initial target population. Experience gained from providing services to these groups will be used to expand services to other population groups in later phases. Excluded from this initial target population are: (1) persons with HIV/AIDS who are primarily cared for through HIV/AIDS programs; (2) persons with long-term mental illness who are primarily cared for through mental health programs; (3) developmentally disabled persons who are primarily cared for through developmental disability programs; and (4) persons who require assistance with one or less activity of daily living, unless they qualify as a result of cognitive impairment.

### **A General Description of Planned Future Phases To Achieve The Broad Program Vision**

The second phase of the Pilot Project will focus on the implementation of capitated managed long-term care. This phase will also be for the initial target population. The second phase will begin with the designation of the permanent long-term care services agency. Once the permanent long-term care services agency is established, all work and responsibilities for the Pilot Project will shift from the transitional long-term care services agency to this designated entity.

The third phase of the Pilot Project will focus on serving the broad target population (all groups requiring long-term care. This may also include: (1) persons with long-term mental illness served by the mental health system; (2) persons with HIV/AIDS served by the CARE system; (3) the developmentally disabled population; and (4) persons who require assistance with one or less activity of daily living. This will include persons who are not Medi-Cal eligible. Significant deliberations involving all concerned groups will be required to establish the appropriateness of serving these individuals in this Pilot Project.

### **Current and Planned Consumer Participation**

Consumers have been actively involved in the design of this Pilot Project. They want to be involved in further planning and implementation, particularly with regard to issues related to consumer decision-making, consumer advocacy, and policy development. Consumers will participate in many activities required to implement the new model of service delivery. This will include: outreach, intake, choice of provider networks, choice of case management options, care plan development, assessment, reassessment, quality assurance, and quality improvement. In accordance with AB 1040, an active advisory committee will have a continuing relationship with the long-term care services agency. The advisory committee will consist of consumers, advocacy groups, and service providers. At least half of advisory committee members will be consumers.



## Preliminary Schedule For Program Development Activities

- Detailed Planning Phase to establish Initial Governance Structure: 6 months
  - a. Determine and designate transitional LTC services agency.
  - b. Develop administrative structures and functions.
- First Phase of Service Delivery For Initial Target Population  
Implementation of Fee-for Service Managed Care: Years 1-3
  - a. Determine waiver authority needed for fee-for-service managed care.
  - b. Initiate fee-for-service managed care for the initial target population.
  - c. Undertake data gathering and analysis.
  - d. Develop detail for second phase implementation.
  - e. Seek an 1115 waiver from Medi-Cal regulations for second phase.
  - f. Finalize development and prepare for second phase implementation.
  - g. Investigate a 222 waiver from Medicare regulations.
- Second Phase of Service Delivery For Initial Target Population  
Implementation of Capitated Managed Care: Years 3-4
  - a. Determine and designate permanent LTC services agency.
  - b. Initiate capitated managed care for the initial target population.
- Third Phase of Service Delivery For the Broad Target Population  
Implementation Capitated Managed Care: Years 5-6
  - a. Initiate capitated managed care for the broad target population.

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<sup>i</sup> City and County of San Francisco, Commission on the Aging: Case Management Plan for Senior Services and Community-Based Long-Term Care, October 1996.







**Laguna Honda Hospital Replacement Planning Committee  
Program Sub-Committee**

(Materials to come as sub-committee analyzes issues and makes recommendations)



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**Laguna Honda Hospital Replacement Planning Committee**  
**Technical Build Sub-Committee**

(Materials to come as sub-committee analyzes issues and makes recommendations)



**Laguna Honda Hospital Replacement Planning Committee  
LIST OF COMMITTEE AND SUB-COMMITTEE MEMBERS**

(The listing of committee and sub-committee members will be  
distributed at the February 9, 1999 meeting)



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